

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03281

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) William T. Addison			2a. DATE OF DEATH MONTH DAY YEAR 2 13 84			2b. HOUR 5:45 A.M.	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 24 01		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTO. County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUP.	
12b. KIND OF BUSINESS OR INDUSTRY L & P. TEL. Co.		13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN PARKVILLE	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2424 LAKEWOOD RD. 21234		14. FATHER'S NAME FIRST MIDDLE LAST Calvin P. Addison		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY S. THORNS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-05-0799		17 INFORMANT ADDRESS FAMILY RECORDS			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) MI  
5695

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION 1/29/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED EXP. LAP. RESECTION OF SM. INTESTINE removal of abscess		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. Baker				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. BAKER				22e. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 15, 1984		23c. NAME OF CEMETERY OR CREMATORY MORRIS MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MARYLAND	
24. FUNERAL DIRECTOR NAME EVANS CHAPEL 800 HARFORD RD.				25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP \_\_\_\_\_

RECEIVED  
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RECEIVED  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										3 2 8 8									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Albert George Albrecht										20. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 2/5/84 19									
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 28 1914 69 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2/5/84 19				24. HOUR 1:50 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 702 & Eastern Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher				12b. KIND OF BUSINESS OR INDUSTRY High School							
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3402 Resh Rd. 210 74									
14. FATHER'S NAME FIRST MIDDLE LAST Adolf Frederick Albrecht										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leola Hoffman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 212-07-7864									
17. INFORMANT Catherine T. Drake										ADDRESS 304 E. Lafayette 36756									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Mitral valvulitis and cardiac hypertrophy</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22. I certify that I have seen the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Thomas D. Smith</i>										TITLE (SPECIFY) Dep. Chief MEDICAL EXAMINER									
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.										ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-9-84		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.									
24. FUNERAL DIRECTOR Thomas D. Fletcher & Son F. H. 254 East Main Street Westminster, Maryland 21157																			
DATE REC'D. BY REGISTRAR FEB 14 1984																			
REGISTRAR'S SIGNATURE <i>Davidson</i>																			

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C. 20315

MEMORANDUM FOR THE SECRETARY OF THE ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, item 21 may injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03289			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>John Walter Almony</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>2 23 1984</i>			2b. HOUR <i>9:24 PM</i>					
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 3 1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>76</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County MD.</i>							
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Joseph's Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Agriculturist</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm</i>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Parkton</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>1043 Stablersville Rd. 21120</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benjamin H. Almony</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillie B. Norris</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>212-40-8162</i>		17. INFORMANT ADDRESS <i>17503 Bunker Hill Rd. George Almony, Parkton, MD 21120</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CVA</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Advanced ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Anemia</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>6/2/17</i> to <i>2/23</i> , 19 <i>84</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death. and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE <i>Natividad D. de Leon, M.D.</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Feb. 26, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>McKendrie Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>White Hall, Harford, MD</i>						
24. FUNERAL DIRECTOR <i>J. J. Hartenstein</i>					Second at Franklin St., New Freedom, PA 17341		25. DATE REC'D. BY REGISTRAR <i>MAR 01 1984</i>					25b. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>	

BP \_\_\_\_\_



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03290

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLEO F. ALVIS</b>		20. DATE OF DEATH MONTH DAY YEAR <b>2 13 84</b>		2b. HOUR <b>6 05 A M</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 - 7 - 61</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>23</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. Co. Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Coast Guard Yard</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1417 Light St. Balto. Md. 21230</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bud ----- Ganten</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eilly ----- Bailey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>236-38-8684</b>		17. INFORMANT ADDRESS <b>Mrs. Ruby Dixon, Same as above</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHIMMEDIATE CAUSE (a) **CARDIORESPIRATORY ARREST**

2765 DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **DEHYDRATION**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**CARCINOMA OF VULVA**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2 - 11 - 19 84</b> , to <b>2 - 13 - 19 84</b> , that (I) (we) last saw the deceased alive on <b>2 - 13 - 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>George Kurian</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2-13-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE KURIAN</b>		22e. ADDRESS <b>Baltimore County General Hospital, MD. 21233</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 16, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Crestlawn Mem. Gardens</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard Co, Maryland</b>
24. FUNERAL DIRECTOR <b>McCully Funeral Home, 130 E. Fort Ave. Balto. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>	25b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



CHIEF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03291

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Bonnie AMOS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 6, 1984</b>		2b. HOUR <b>8:27am</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 23 1956</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>27</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Franklin Sq. Hospital</b>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>Welder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Instrument Co.</b>
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Middle River</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bill Hess</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Collen Shaw</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213 76 8257</b>		17. INFORMANT ADDRESS <b>Edgar Amos, Jr. Husband Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>0389</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT HOME <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>February 4, 1984</b> to <b>February 6, 1984</b> , that (I/we) last saw the deceased alive on <b>February 6, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (he) (we) (did) (do) not view the body after death.					
22b. SIGNATURE <b>Allan Gittman</b>		DEGREE		22c. DATE SIGNED <b>2/6/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allan Gittman, M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/8/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gardens</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD.</b>					
24. FUNERAL DIRECTOR <b>Brzezinski Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lewis</b>	

1866

124



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 & 6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE OF DEATH			KNOWN ESTI-MATED			MONTH DAY YEAR			2d. HOUR								
BERTHA M. ARMSTRONG												2-15-1984			1000 M								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR							
F		W		3-26-1910		73 YRS.						2-15-1984				1900 M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND				U.S.A.								BALTIMORE COUNTY - MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
BALTO.				1603 GAIL RD				HOMEMAKER				HOME											
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
MD.				BALTO.				BALTO.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				1603 GAIL RD. 21221							
14. FATHER'S NAME FIRST MIDDLE LAST								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
CHARLES BREHM								LYDIA JOHNSON															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.								17. INFORMANT ADDRESS							
No								212-18-24218								Mr. James M. Armstrong - 1603 Gail Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4310 IMMEDIATE CAUSE (a) <u>Acute intracerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE				J. Crossan O'Donovan				TITLE (SPECIFY)				Deputy				MEDICAL EXAMINER							
EXAMINER'S NAME (TYPE OR PRINT)				J. CROSSAN O'DONOVAN				ADDRESS				2112 Dundalk Ave., Balto., Md. 21222				DATE SIGNED							
																2/15/84							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL				2-18-84				HOLLY HILLS Cem.				BALTO., MD.											
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Jeffrey Miller - 2334 Jefferson St.				FEB 17 1984				John Davidson-Randall															





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03293

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KATHERINE N. ARMSTRONG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 11, 1984</b>		2b. HOUR <b>M</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 24 1890</b>	6. AGE (IN YEARS (LAST BIRTHDAY)) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Lutherville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>College Manor</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>204 E. Joppa Road 21204</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Nebel</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Mueller</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>Q79-05-6053</b>	17. INFORMANT ADDRESS <b>Mrs. Claire Koeppel, 610 E. Seminary Ave. 21204</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*Congestive Heart Failure*

4292  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

*arteriosclerotic Cardiovascular Disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 22 1983</b> to <b>FEB 11 1984</b> , that (I) (we) lost saw the deceased alive on <b>FEB 11 1984</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <i>Kevin Quinn</i>		DEGREE <b>M.D.</b>	22c. DATE SIGNED <b>2/13/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kevin Quinn M.D.</b>		22e. ADDRESS <b>1205 York Road, Lutherville, Maryland 21093</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>2-13-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Westview Crematory  
1000 Westview Drive  
Denver, Colorado 80202

WESTVIEW CREMATORY

20% OFF

Westview Crematory

4-13-84

REG. NO.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

23b. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>3/3/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Plesant Mill Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Glasgow,</b> COUNTY <b>Pa.</b> STATE
24. FUNERAL DIRECTOR NAME <b>WOODLAWN MEMORIAL FH, 6411 Windsor Mill Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1984</b>	25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 03295				
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>CLARA Barton ASHLEY</b>					2a. DATE OF DEATH MONTH DAY YEAR 2 8 '84				
3. SEX <b>FEMALE</b>					2b. HOUR 4:30AM				
4. RACE <b>Caucasian</b>					5. DATE OF BIRTH MONTH DAY YEAR 10 11 1899				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>					6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.				
7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>GBMC-6701 N. CHARLES ST.</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired-Phone Company</b>				
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>				
13c. CITY OR TOWN <b>Pikesville</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Hanft</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan Horr</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>220-07-1723 A</b>				
17. INFORMANT <b>Mr. Melvin B. Ashley</b>					ADDRESS <b>3216 Marnet Road Baltimore, Md. 21208</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4273 IMMEDIATE CAUSE (a) MULTIPLE CEREBRAL EMBOLI</b> DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: <b>ATRIAL FIBRILLATION</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>1-23</b> <b>84</b> to <b>2-08</b> <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-08</b> <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Raymond A. Nze</b> MD					22c. DATE SIGNED <b>2/8/84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYMOND A. NZE, M.D.</b>					22e. ADDRESS <b>6701-N. CHARLES ST.-GBMC</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>2-11-84</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore Maryland</b>				
24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, Inc.</b>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 10 1984</b>				
8728 Liberty Road Randallstown, Maryland 21133									

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SHLEY

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REM 12

BALTIMORE COUNTY

68MC-6701 N. CH. RLES ST.

TOWSON

MULTIPLE CEREAL L ENROLL

TRIAL FIRMATION

X

LA 2-08 8A

1-53

5-08

6701-N. CH. RLES ST.-GBMC

R. YONKOW, NEE, M.D.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03296

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELEANOR G ATERS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 29 84</b>		2b. HOUR <b>11<sup>PM</sup></b>		
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 25 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. County Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Buyer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
13a. STATE <b>Md.</b>		13b. CITY <b>Glen Burnie</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>96 E. Howard Rd. 21061</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Green</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-03-4998</b>		17. INFORMANT <b>Ms. Carla Martin</b>		ADDRESS <b>Balto., Md. 5519 Clifton Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>5715</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CIRRHOSIS OF LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/29</b> 19 <b>84</b> to <b>2/29</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/29</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R. DEPESTRE M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. DEPESTRE M.D.</b>				22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSP.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>2/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25. DATE REC'D. BY REGISTRAR <b>FEB 05 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be kept with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha Y. BACHTELL			2a. DATE OF DEATH MONTH DAY YEAR February 27, 1984		2b. HOUR 1:04am	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 5 1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Garment
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Balt. City		13c. CITY OR TOWN Baltimore	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 14 Carriage Lane 21220			
14. FATHER'S NAME FIRST MIDDLE LAST John E. Youngblood			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan V. Spiker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 173-14-3370		17. INFORMANT ADDRESS James M. Bachtell same as 13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Pulmonary Infarct (c) Pulmonary Embolus, Gastric Ulcer With Bleeding DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 13, 1984 to February 27, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 27, 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.						
22b. SIGNATURE Albert K. [Signature]		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-27-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert Lee. M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/1/1984		23c. NAME OF CEMETERY OR CREMATORY Greenway Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Berkeley Springs Morgan W. Va.
24. FUNERAL DIRECTOR NAME Richard J. [Signature]		24b. ADDRESS [Signature]		25a. DATE REC'D. BY REGISTRAR MAR 1 2 1984		
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03298			
1. DECEASED NAME (TYPE OR PRINT) <b>Grason Elmer Ballard</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 5, 1984</b>				2b. HOUR <b>11 pm</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 30, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Pikesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8 Brightside Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bus Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Pikesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8 Brightside Ave. 21208</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Sinclair Ballard</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Virginia Huber</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-03-0296</b>		17. INFORMANT ADDRESS <b>8 Brightside Ave., Irma S. Ballard Pikesville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASCD</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1hr.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Gen Adrenocortical + Senile Dementia</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>7-5</b> 19 <b>73</b> , to <b>2-5</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>12</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. Steven Margolis</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/6/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. Steven Margolis M.D.</b>				22e. ADDRESS <b>70 F Painters Mill Rd. Owings Mills, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb. 7, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial Gar.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Finksburg, Carroll, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>H. E. Echhardt</b>				24b. ADDRESS <b>Owings Mills, Maryland</b>				25. DATE REC'D. BY REGISTRAR <b>FEB 09 1984</b>			
								25b. REGISTRAR'S SIGNATURE <b>John J. Lough</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HOWARD J. BANGERT</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>2 / 1 / 84</b>		2b. HOUR <b>12:11 A</b>
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 20 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wire Inspector Western Elect</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>718 North Pt. Rd. 21224</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Bangert</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW I</b>		17. INFORMANT <b>George J. Bangert</b>		ADDRESS <b>718 North Pt. Rd. Balto., MD. 21224</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5860 RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PNEUMONIA AND ALZHEIMER'S DISEASE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Beatrice P. Dizon, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/1/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 7 - 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Bea J. Connel</b>	

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UNITED STATES DEPARTMENT OF AGRICULTURE  
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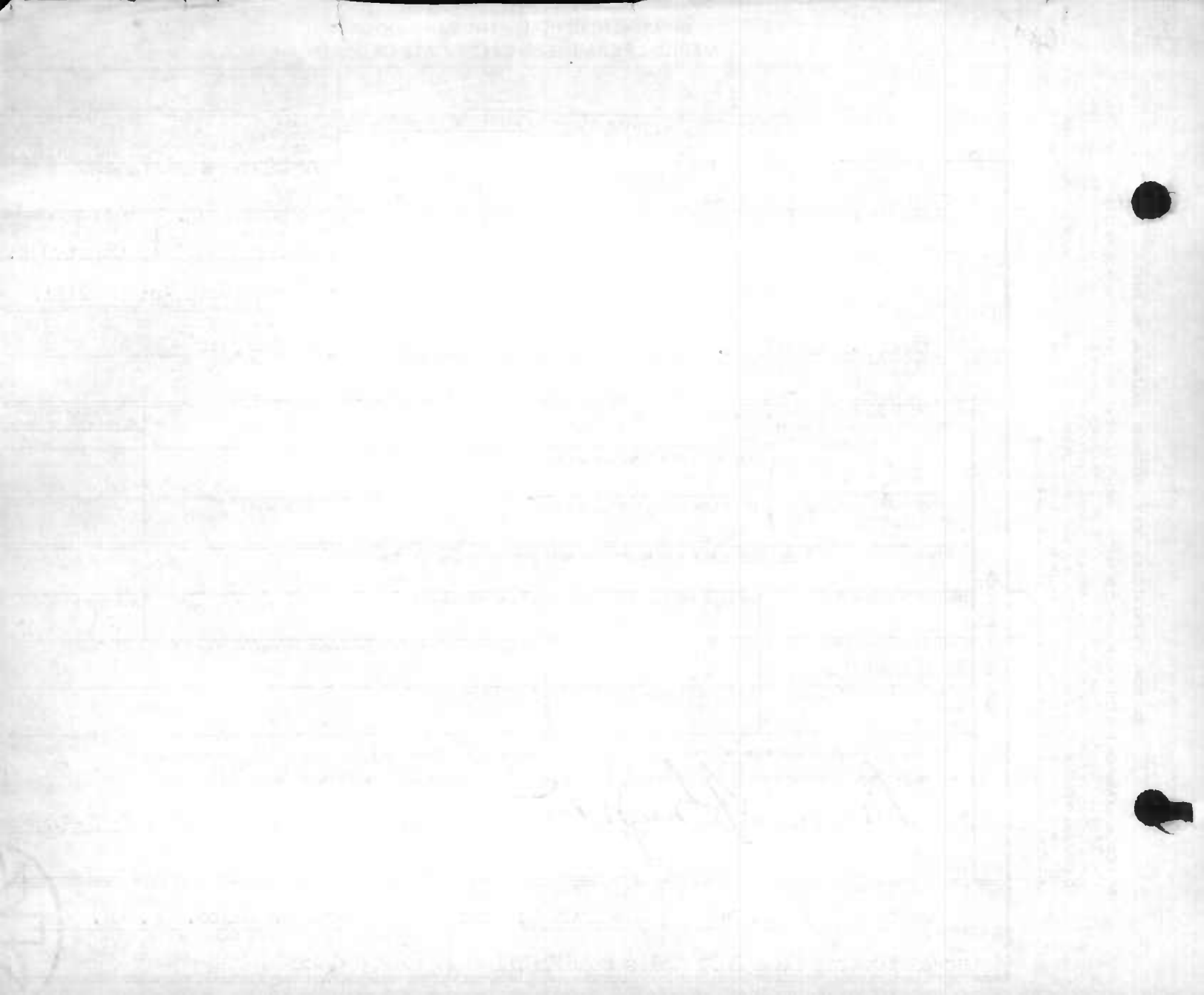
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Sammy K. Barnes</b>							2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2-20 19 84</b>		2b. HOUR M <b>1:53 a.m.</b>		
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 4, 1943</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN <b>40 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2-20 19 84</b>		7d. HOUR M <b>1:53 a.m.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construct.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md</b>		13b. COUNTY <b>Baltimore Co</b>		13c. CITY OR TOWN <b>Owings Mills</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1 Shasta Circle Apt H 21117</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William P. Barnes</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elva Teague Sterner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>1962-64 230 54 7363</b>		17. INFORMANT ADDRESS <b>Elva Sterner same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>5718 IMMEDIATE CAUSE (a) Fatty Liver</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>						TITLE (SPECIFY) <b>M.D. Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>2-20-84</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>						ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/22/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Balto. Co. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Burgee Funeral Home 3631 Falls Road 21211</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 22 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03301

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Bernard N. Barr</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 27 84</b>			2b. HOUR <b>740 PM</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BANDPLUSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>OWINGS MILLS</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4 HIAWATHA CT. APT. A (21117)</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM BARR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DORA WHITMAN</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216-01-4563</b>	
17. INFORMANT ADDRESS <b>STANLEY BARR 120 GREEN VALE RD. CHERRY HILL, NJ</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> <b>2000</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Histiocytic Lymphoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive heart failure, ASH-D</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>HAFEEZ A SYED</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/27/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAFEEZ A SYED</b>			22e. ADDRESS <b>BALTIMORE COUNTY GEN HOSP.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/29/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HAR SINAI CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>OWINGS MILLS BALTIMORE MARYLAND</b>				
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Hendall</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Russell Leo Barrett</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>2 8 1984</b>				
3 SEX <b>male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 6 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>		7b. HOUR <b>5:45 AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7616 Old Battle Grove Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bar Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>self Emp</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry R Barrett</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret O'Laughton</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>215 01 9704</b>		17. INFORMANT ADDRESS <b>Mrs. Clara Barrett 7616 Old Battle Grove Rd</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>above</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ 1 yr.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>7/11/83</b> , 19____, to <b>Present</b> , 19____, that (I) (we) lost saw the deceased alive on <b>12-21-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Heymon Weiner</b>			DEGREE <b>S. WEINER</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/8/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. WEINER</b>			22e. ADDRESS <b>1900 E. Northern Pkwy.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/11/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Walter Dabrowski</b>					ADDRESS <b>1005 Dundalk Avenue</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1984</b>		
					25b. REGISTRAR'S SIGNATURE <b>John Dabrowski</b>				

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СЕРГЕЕВ АЛЕКСАНДР СЕРГЕЕВИЧ

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03303

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Ellen Rose Bayne</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Feb. 15, 1984</i>		2b. HOUR <i>7:45P</i> M						
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 9, 1891</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Towson Convalescent Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>at home</i>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Timonium</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>103 Gorsuch Road 21093</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>PETER BARROWS</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNA EMMA BARROWS</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>			16b. SOCIAL SECURITY NO. <i>213 74 2499</i>			17. INFORMANT ADDRESS <i>family records</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from <i>Feb 7<sup>th</sup></i> , 19 <i>84</i> , to <i>Feb 15<sup>th</sup></i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>Feb 7<sup>th</sup></i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Kevin Quinn</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>2/17/84</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kevin Quinn, M.D.</i>			22e. ADDRESS <i>1205 York Road</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>			23b. DATE <i>2/20/84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Towson, Balto. County, MD.</i>			
24. FUNERAL DIRECTOR NAME <i>Evans Chapel of Chimes</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 21 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>			
ADDRESS <i>2325 York Road</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Beatrice Emily BEAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>February 8, 1984</b>			2b. HOUR <b>8:16 P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 29 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>200 Garden Road 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Francis Godman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Daisy Lilly Arminger</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>820-01-7676</b> <del>XXXXXXXX</del>		17. INFORMANT ADDRESS <b>Mrs. E.E. Zepp 200 Garden Road Apt. A 21204</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5319</b> IMMEDIATE CAUSE (a) <b>Sepsis secondary to staphylococcus</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gastric ulcer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>no</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 26</b> , 19 <b>84</b> , to <b>Feb. 8</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>Feb. 8</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M. L. Anderson</i>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>2/8/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. L. Anderson, MD</b>					22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-11-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie A.A. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>					25. DATE RECD. BY REGISTRAR'S SIGNATURE <b>FEB 16 1984</b> <i>J. Davidson-Randall</i>				
ADDRESS <b>6500 York Rd.</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR <b>SAMUEL P. BENEDETTA</b>										03305	
1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL P. BENEDETTA</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>2 15 84</b>			2b. HOUR M <b>M</b>		
3. SEX <b>MALE</b>		4. RACE <b>W CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 01 26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>57</b>		IF UNDER 24 HRS. HOURS MIN. <b>57</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALT. COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>ROSEDALE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8117 OLD PHILADELPHIA RD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERVISOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCT.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>			13c. CITY OR TOWN <b>ROSEDALE</b>		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <b>8117 OLD PHILADELPHIA RD. 21237</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH BENEDETTA</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTHER</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW II 217200980</b>			17. INFORMANT ADDRESS <b>CAROLYN BENEDETTA 8117 OLD PHILA. RD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMOPERICARDIUM</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>LEAKAGE AT ANASTOMATIC SITE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY BYPASS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <b>SEVERE CORONARY ARTERIOSCLEROSIS</b>											
19a. DATE OF OPERATION <b>2/1/84</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CORONARY ARTERY DISEASE</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Sam J. Misaniuk</b>			DEGREE <b>L. MISANIUK M.D.</b>			22c. DATE SIGNED <b>2/15/84</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <b>ST. JOSEPH HOSPITAL</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/20/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEL AIR MEM. GAR.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BEL AIR HARFORD MD.</b>				
24. FUNERAL DIRECTOR <b>Bel Air</b>			ADDRESS <b>1211 Chesano Ave</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

7 3 3 0 6

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GRACE M. BENSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 5, 1984</b>		2b. HOUR <b>10<sup>30A</sup> M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 26, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>714 Camberley Circle</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>MD</b>		13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Schubel</b> <b>Murrow</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary</b> <b>Osborne</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>215 07 9261</b>		17. INFORMANT ADDRESS <b>Mrs. Patricia Colvard, Fallston, MD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERTENSIVE ARTERIOSCLEROTIC HEART DIS</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 years</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>PULMONARY AND SPLENIC EMBOLISM (6 months previous)</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>01-12</b> , 19 <b>84</b> , to <b>02-05</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>01-12</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.								
22b. SIGNATURE <b>Anthony A. Lewandowski</b> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>02-06-84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Anthony A. Lewandowski, M.D.</b>				22e. ADDRESS <b>7402 York Road, Balto., MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/8/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Co., MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Henry W. Jenkins &amp; Sons Co.</b> <b>4905 York Road Balto., MD 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 9 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and cause noted.

Film G588 Item 2b

1- STATE REGISTRAR 2/18/84 rja

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nannie Hill BENTLEY			2a. DATE OF DEATH MONTH DAY YEAR February 3 1984			2b. HOUR 10:30 A					
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR June 12 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Towson Convalescent Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY - - - - -			
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 301 W. Chesapeake Ave 21204		
14. FATHER'S NAME FIRST MIDDLE LAST Jordan Hill			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Ellen Holbrook			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No - - - - -				16b. SOCIAL SECURITY NO. 289 05 8786	
17. INFORMANT ADDRESS 21030			Mrs. William R. Bentley, 10854 York Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Resp arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>awk</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>ASCVD cuts cardiac blood syndrome</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-15</u> , 19 <u>82</u> , to <u>2/3</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard D. Maffezzoli</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/16/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard D. Maffezzoli						22e. ADDRESS 660 Kenilworth Drive					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE 6 FEB 84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Ceme.		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium, Maryland				
24. FUNERAL DIRECTOR <u>J. E. Lowell Lemmon</u>						25a. DATE REC'D BY REGISTRAR FEB 7 1984		25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>			

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Handwritten notes and bleed-through from the reverse side of the page, including names like "J. E. Lowell" and "P. E. Lowell", and various illegible scribbles.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03308

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>George H. Berg</b>			2a DATE OF DEATH MONTH DAY YEAR <b>February 19 1984</b>			2b HOUR M <b>AM</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>August 12, 1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>71 YRS.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>	
10 CITY OR TOWN OF DEATH <b>Lansdowne</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>300 Wisewell Court</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>sales</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13a STATE <b>Maryland</b>		13b COUNTY <b>Anne Arundel</b>		13c CITY OR TOWN <b>Severna Park</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Berg</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Hartman</b>		13e STREET ADDRESS <b>795 Woods Road 21122</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-09-7265</b>		17 INFORMANT <b>Mr. George N. Berg</b>		ADDRESS <b>795 Woods Rd. 21122</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>metastatic lung cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>metastatic lung cancer</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 months</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerotic Heart Disease</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2-10 1984</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>84 2-10 84</b>			
22a I certify that (I) (this hospital) attended the deceased from <b>2-4</b> 19 <b>84</b> , to <b>2-10</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2-10</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Long Hsu</b>				DEGREE <b>M.D.</b>		22c DATE SIGNED <b>2/19/84</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Long Hsu, M.D.</b>				22e ADDRESS <b>North Arundel Hospital</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b DATE <b>2/22/84</b>		23c NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cem.</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Howard Maryland</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Ambrose Funeral Home 1328 SULPHUR SP. RD.</b>				25a DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>		25b REGISTRAR'S SIGNATURE <b>Juha Davidson-Randell</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03309

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Myra Esther BERKOFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2/23/84</b>			2b. HOUR <b>1124 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept, 11, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>5 12 11 24</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY. MD.</b>				
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SINAI HOSP OF BALTO</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bookkeeper</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>					13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Berkoff</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Gifter</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>N/A.</b>		17. INFORMANT <b>6104 Pimlico Rd., Balto. 21209</b> <b>Mr. Hyman Berkoff (Brother)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>7331 Cardio - respiratory arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b). <b>Hypovolemic - hemorrhagic shock? 6 hrs.</b> DUE TO, OR AS A CONSEQUENCE OF (c). <b>Femur fracture (Pathologic)? 8 hrs.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Metastatic Breast carcinoma.</b>										
19a. DATE OF OPERATION <b>Ø</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ø</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>2/23, 19 84</b> to <b>2/23, 19 84</b> , that (I) (we) last saw the deceased alive on <b>2/23, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Marc Siegelbaum MD</b>					DEGREE		22c. DATE SIGNED <b>2/23/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARC SIEGELBAUM MD</b>					22e. ADDRESS <b>SINAI HOSP OF BALTO.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>26 FEB'84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth Tifiloh Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>			
24. FUNERAL DIRECTOR NAME <b>J. Shannon</b>					25a. DATE RECD. BY REGISTRAR <b>FEB 28 1984</b>					
HEBREW MEMORIAL Funeral Home, Pikesville, Md.										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

RECEIVED

Station

X

Land

BOOKS

Baltimore

Harford

Harford

Office

Station

Station Rd., also. 5100

Mr. William Verkuil (brother)

N/A.

NO

Baltimore

25 02184 Beth Tifion Cam.

Initial

Harford, Pikeville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR XC 2027646 STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST JOHN JOSEPH BEYER				FEBRUARY 25, 1984			
2b. HOUR 11:50P <sub>M</sub>							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 22, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) V.A. MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tavernkeeper		12b. KIND OF BUSINESS OR INDUSTRY Tavern	
13a. STATE MARYLAND				13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES (NM) BEYER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE KRAUSE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW I 218 32 2668		17. INFORMANT ADDRESS Marguerite Beyer, 2332 Holly Neck Rd., Baltimore, Md. 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) S/P MI APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that X (this hospital) attended the deceased from FEBRUARY 22, 19 84, to FEBRUARY 25, 19 84, that X (we) lost saw the deceased alive on FEBRUARY 25, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (do not) view the body after death.							
22b. SIGNATURE Piero Autuono M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-26-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PIERO AUTUONO, M.D.				22e. ADDRESS VAMC, FORT HOWARD, MD 21052			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 2/28/84		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		23d. LOCATION Baltimore, Maryland STATE	
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR FEB 27 1984		25b. REGISTRAR'S SIGNATURE Rendell	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be retained until 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 1B, known any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03311

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGUERITE S. BISHOP</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02 29 '84</b>			2b. HOUR A M <b>7:00 A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 31, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Owings Mills, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired U.S. Government</b>	
12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b>				13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Edgewood</b>	
				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1918 Harbinger Trail 21040</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Horace Strewig</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Higgs</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-42-4801</b>		17. INFORMANT ADDRESS <b>Mrs. Beverly A. Spears Edgewood, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b> <b>5849</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/16</b> , 19 <b>84</b> , to <b>2/29</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/29</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Joann Donaldson</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/16/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOANN DONALDSON, M.D.</b>				22e. ADDRESS <b>GBMC - 6701 N. CHARLES STREET 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Mar. 2, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Eline Funeral Home Reisterstown, Md</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Car. Swindon-Randall</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
James Blake				Feb. 15, 1984 6:45a M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		BLACK		1 25 1881		103 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Catonsville MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		Bland Bryant Nursing Home					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Unknown				Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Unknown				265-05-9757		Spring Grove Nursing Center	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Myocardial infarction							
4100							
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular disease							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
Chronic Renal Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 2-14-1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
D. S. SALUGA MD							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
DARSHAN S. SALUGA MD		P.O. Box 3235, Balts 21228					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		2/17/84		Mount Auburn Cem.		Baltimore, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm C March F/H Inc. 1101 E North Avenue				FEB 16 1984		Davidson-Randall	

BP \_\_\_\_\_

DHMH-16 20M  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03313

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Frances Bernice Blouse</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 29, 1984</b>		2b. HOUR M <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 23, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rosedale</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HomeMaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Owings Mills</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>123 Willowbend Drive 21117</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John E. Beck</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy L. Meekins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-28-2640</b>		17. INFORMANT ADDRESS <b>Mr. Mervin W. Blouse</b> <b>76 Palmsetta Court Westminster, MD. 21157</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100 Myocardial Infarction</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1974</b> , 19 <b>84</b> , to <b>84</b> , that (I) (we) lost saw the deceased alive on <b>1/27</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jerome H. Ginsberg</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>3/1/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Jerome Ginsberg</b>		22e. ADDRESS <b>5310 Old Court Road 21133</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3-3-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>		ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b>		25. REGISTRAR'S SIGNATURE <b>John Davidson-Pondell</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03314

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Carolyn Lynne Blye</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 11, 1984</b>			2b. HOUR <b>8:40 P</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 8 1958</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>25</b>		7. UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto County MD</b>				
11. CITY OR TOWN OF DEATH <b>Towson MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Asst. Mgr</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Loyola college</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Hanover</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1900 Ridgewood RD 21076</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earl D. Sheets</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances E. Vellucci</b>			17. INFORMANT ADDRESS <b>Mr. Benjamin F. Blye IV, Same as Sec. 13</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>217-66-3254</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic colonic carcinoma</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>7 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>JAN. 7</b> , 19 <b>84</b> , to <b>Feb 11</b> , 19 <b>84</b> , that (we) lost the deceased alive on <b>Feb 11</b> , 19 <b>84</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (do not) view the body after death.										
22b. SIGNATURE <b>Arnold Henson MD</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/11/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arnold Henson</b>			22e. ADDRESS <b>St. Joseph Hospital, Towson Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 14, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leroy A. &amp; Russell C. Witzke Funeral Homes P.A.</b> ADDRESS <b>5555 Twin Knolls Rd., Columbia, Maryland 21046</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Harrison</b>		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CLEE M. BOLYARD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>FEB 29 1984</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5/3/12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>MIDDLE RIVER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>39 KERRIA LN.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SMELTING</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SMELTING</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>MIDDLE RIVER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FELIX BOLYARD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ETHEL FUNK</b>		13e. STREET ADDRESS <b>39 KERRIA LN. 21220</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNK</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>236 03 9276</b>		17. INFORMANT ADDRESS <b>FRIEDA BOLYARD ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of bile duct.</b> <b>1561</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Coronary Heart Disease with past Extensive Myocardial Infarction</b>							
19a. DATE OF OPERATION <b>4/12/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Drain, take bile duct - to relieve obstruction</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3/29 19 83 to 2/29 19 84</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/29 19 83</b> to <b>2/29 19 84</b> , that (I) (we) lost saw the deceased alive on <b>4/31 19 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ernest N. Arnett, M.D.</b>				DEGREE <b>MD.</b>		22c. DATE SIGNED <b>21237</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ernest N. Arnett, M.D.</b>				22e. ADDRESS <b>9101 Franklin Sq. Dr., Balto. Md.,</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/3/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>J.G. CONNELLY 300 MALE</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Wilson Handell</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Nicholas		S.		BOND	February 20, 1984			1:13am <sub>M</sub>	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male	Black		12 9 1917		66			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. BALTIMORE CITY OR COUNTY OF DEATH	
Balto, Md.	U. S. A.				Baltimore County			MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Franklin Square		Chauffeur		TRACTOR-TRAILER					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS / ZIP CODE			
Md.		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8739 FONTANA LA. 21234			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
William		Sarah		Yes		218-09-485		Mrs. Alma Bond 125 Lee Lawrence Ct. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY:		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4100		Acute myocardial infarction		Hypertensive cardiovascular		Disease			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET					
22a. I certify that (I) (this hospital) attended the deceased from 1/13/84 to 1/13/84, and that (I) (we) last saw the deceased alive on 1/13/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Theodore Patterson, M.D.		M.D.		2/21/84			
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY (IF CREMATION, GIVE LOCATION)		23d. ADDRESS			
Burial		2-24-83		Crownsville, Md.		21222 Crownsville, Md.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
JAS. A. MORTON & SONS		1701 LAURENS		FEB 22 1984		Davidson-Hendall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as being unknown, injury, or other traumatic event, the medical examiner must be notified also.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN J. BOSS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 10 '84</b>			2b. HOUR <b>5:33A M</b>				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 28, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Resident Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Rental</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21234</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Peter Boss</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Theresa Marx</b>			13e. STREET ADDRESS / ZIP CODE <b>8653 Hoerner Avenue 21234</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>1947-51</b>		17. INFORMANT ADDRESS <b>Dorothy M.S. Boss 8653 Hoerner Ave. 21234</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> , 19 <b>84</b> , to <b>2/10</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2/10</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED <b>2/10/84</b>	
22b. SIGNATURE <i>Mark Davis</i>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK DAVIS, M.D.</b>			22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>			23b. DATE <b>Feb. 13, '84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Gar. Balto. Co., MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>			ADDRESS <b>8521 Loch Raven Blvd.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		

BP

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JOHN

BOSS

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BUTTINORE COUNTY

TOMSON

GENIC-2711 N. CHILES ST.

C. ROIC BREEST

WYOC POLICE THE SECTION

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GENIC-2711 N. CHILES ST.

W. W. D. VIE, W.D.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03318

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Christina Elizabeth BOUVIER			2a. DATE OF DEATH MONTH DAY YEAR 02 19 84			2b. HOUR 9:10PM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 18 84		6. AGE (IN YEARS LAST BIRTHDAY) 1 DAY YRS		7. IF UNDER 1 YEAR MONTHS DAYS 1	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (GBMC) 6701 NORTH CHARLES STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Not Applicable		12b. KIND OF BUSINESS OR INDUSTRY Not Applicable	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3 Reldas Ct., 21030	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Earl Bouvier				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Elizabeth Harper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Apt. K Mr. & Mrs. Thomas E. Bouvier, 3 Reldas Ct.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7400 CARDIO RESPIRATORY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ANENCEPHALY (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 02 - 18, 19 84, to 02 - 19, 19 84, that (I) (we) last saw the deceased alive on 02-19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Zahida Saleem Haque						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ZAHIDA SALEEM HAQUE						22e. ADDRESS 6701 NORTH CHARLES STREET (GBMC)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/22/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Timonium Balto. Md.		
24. FUNERAL DIRECTOR NAME Martin D. Lawson, 10 W. Padonia Rd. 21093						25a. DATE REC'D. BY REGISTRAR FEB 21 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5/21/8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR		REG. NO. 03319							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Ruth Emma BOYLAN				2a. DATE OF DEATH MONTH DAY YEAR February 29, 1984		2b. HOUR 12:40 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 26 22		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY homemaking	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4107 Asbury Ave. 21236	
14. FATHER'S NAME FIRST MIDDLE LAST James H. Sieling				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Kraft					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no				16b. SOCIAL SECURITY NO. 214-14-4126		17. INFORMANT ADDRESS James H. Sieling 2608 Canterbury Rd. Balto., Md. 21234			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> years DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary artery disease</u> years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>July</u> , 19 <u>83</u> , to <u>Feb 29</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Walford				22e. ADDRESS 9101 Franklin Square Dr. 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-3-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County Maryland			
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		24b. ADDRESS 7401 Belair Rd. Balto., Md. 21236		25. DATE REC'D. BY REGISTRAR MAR 06 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03320	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Catherine Belz BRIDGE						2a. DATE OF DEATH MONTH DAY YEAR February 26, 1984			2b. HOUR 5:53A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22 1903		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY BALTO. CITY SCHOOLS			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY -		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4115 CHESTERFIELD AVE. 21213			
14. FATHER'S NAME FIRST MIDDLE LAST John Bridge					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mathilda Belz						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 213-01-7359		17. INFORMANT ADDRESS AGNES ROWLES (NIECE) 3804 KIMBLE RD. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 3, 19 84, to February 26, 19 84, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE Darius Russin				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Darius Russin, M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/29/84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213						25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03321

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>KARL B. BROCKMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 3 84</b>		2b. HOUR <b>6:45 AM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 19 31</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ATTORNEY</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>AT LAW</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY COUNTY <b>MARYLAND BALTO. BALTIMORE</b>			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13c. STREET ADDRESS / ZIP CODE <b>4770 BYRON RD. #21208</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL BROCKMAN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LEAH KISHTER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES KOREAN</b>		16b. SOCIAL SECURITY NO. <b>220-24-3456</b>	17. INFORMANT ADDRESS <b>MRS. HANNAH BROCKMAN</b> <b>4770 BYRON RD. BALTO., MD 21208</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>24 Hrs.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Diabetes Mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2-1</b> , 19 <b>84</b> , to <b>2-3</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2-3</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE <b>Lawrence Solomon MD</b>		DEGREE <b>MD</b>		27c. DATE SIGNED <b>2-3-84</b>	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAWRENCE SOLOMON M.D.</b>		27e. ADDRESS <b>600 Reisterstown Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>FEB. 5, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03322

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELAINE HOLLAND BROWN			2a. DATE OF DEATH MONTH DAY YEAR Feb. 17, 1984		2b. HOUR 6:30 P.M.
1. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 22, 1948	6. AGE (IN YEARS LAST BIRTHDAY) 35 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH LUTHERVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 502 SPRING AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Balto.	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John E. Holland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elaine Dowell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 48 1356		17. INFORMANT ADDRESS Craig S. Brown, Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 2396 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain tumor</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-26</u> 19 <u>83</u> , to <u>2-17</u> 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>1-20</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Howard Moses</u>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-17-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Howard Moses</u>		22e. ADDRESS <u>101 W. Read St 21201</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/20/84		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., MD		23e. DATE REC'D. BY REGISTRAR FEB 21 1984			
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212		25. REGISTRAR'S SIGNATURE <u>J. Davidson-Randell</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and advised.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				0 3 3 2 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ESTHER BROWASTEIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>SATURDAY, FEB. 4, 1984</b> 2b. HOUR <b>8:55A<sub>M</sub></b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 15, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. OF EDUCATION</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB BROWNSTEIN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE ALPER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)			
16b. SOCIAL SECURITY NO. <b>212-01-5946</b>		17. INFORMANT ADDRESS <b>WOODSTOCK, MD.</b>		17. INFORMANT ADDRESS <b>MRS. EVA GRANER 3122 HERNWOOD RD. (21163)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1830 pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>or bleed.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>sepsis ovarian cancer.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>19</b> , to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>L.R. Peredom</b> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/4/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L.R. PEREDOM</b>				22e. ADDRESS <b>BALTIMORE COUNTY GEN HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (S) <b>BURIAL</b>		23b. DATE <b>2/5/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>REISTERSTOWN, BALTIMORE, MD.</b>	
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>				25a. DATE REC'D BY REGISTRAR <b>FEB 10 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Grier</b>	
6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)							

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

1

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[illegible text follows in several lines]

FOR COLLECTION  
[illegible text]



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03324

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mr., Wilmer A. Brumbaugh			2a. DATE OF DEATH MONTH DAY YEAR February 1 1984			2b. HOUR 12:15 PM		
1. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 16 1887		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Gov't		
						12b. KIND OF BUSINESS OR INDUSTRY Engineers		
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN 7600 Clays Lane		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Reuben H. Brumbaugh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Miller Brumbaugh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 426-07-8478		17. INMATE ADDRESS Mrs. Leah Brumbaugh 7600 Clays Lane Baltimore Maryland		21207		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

4860 IMMEDIATE CAUSE (a) PNEUMONIA  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1, (a).  
ARTERIO-SCLEROTIC AND AORTIC DISEASE, CONGESTIVE HEART FAILURE, PERMANENT PNEUMONIA, RENAL FAILURE

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-4, 1984, to 2-1, 1984, that (I) (we) last saw the deceased alive on 2-1, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Connan</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2-1-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ORLANDO B. CONNAN M.D.				22e. ADDRESS BCGH - RANDALLSTOWN Md. 21133			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02-04-84		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE <i>Joan J. Conner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner must be notified at once.

BP



NO. 201

*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*



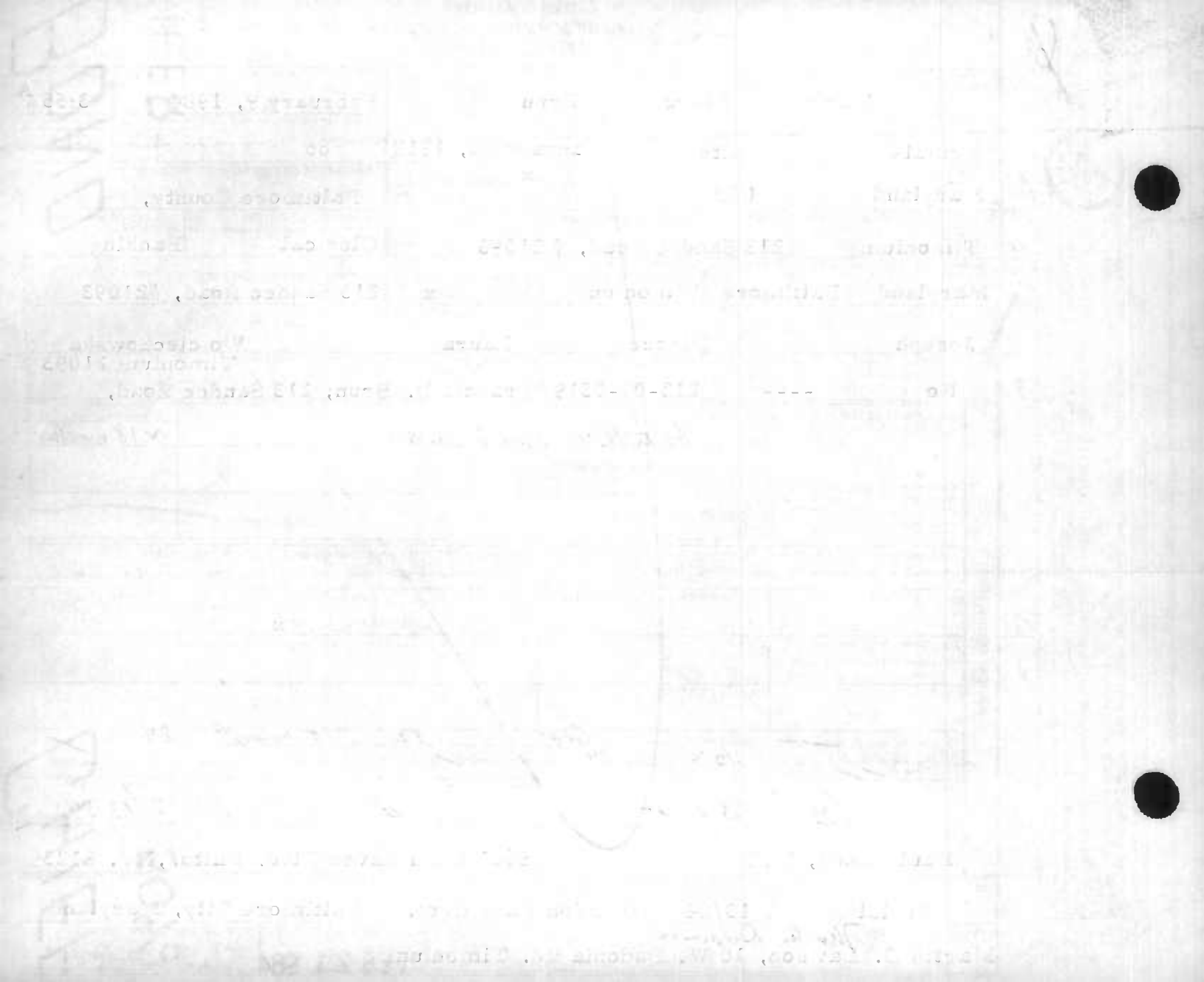
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					February 9, 1984							3:55 A <sup>M</sup>		
3. SEX			4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female			White		January 20, 1918			66						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland			USA					Baltimore County, MD.						
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Timonium					213 Sandee Road, # 21093					Clerical			Banking	
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland					Baltimore		Timonium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		213 Sandee Road, #21093			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Joseph Pierce					Laura Wojciechowska									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No					-----		212-07-0319 Francis B. Brun, 213 Sandee Road.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Monotonic breast cancer</u> <u>1749</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~18 months</u>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>Sept.</u> 19 <u>82</u> , to <u>February 9</u> 19 <u>84</u> , that (I) <u>we</u> last saw the deceased alive on <u>12/3</u> 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.														
22b. SIGNATURE <u>Paul Chang, M.D.</u>				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/13/84</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS										
Paul Chang, M.D.				5601 Loch Raven Blvd. Balto., Md. 21239										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial				2/13/84		Loudon Park Cem.				Baltimore City, Maryland				
24. FUNERAL DIRECTOR NAME <u>Martin D. Lawson</u>				ADDRESS <u>10 W. Padonia Rd. Timonium</u>				25a. DATE REC'D. BY REGISTRAR <u>FEB 21 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randell</u>				

BP \_\_\_\_\_







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
Doroy Clayton Burnham SR.			2-23-84			10 A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		3 6 81		8 2		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md		U.S.				Balt. Co. Garrison, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Garrison		Garrison Valley Center				Stone Mason			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md		Howard		West Friendship		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3116 Rt. 32 West Friendship Md 21794	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)							
John Burnham		Mary Fishbaugh							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		215-22-9752		Chart & Family					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate</u> 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>ASHD, CHF, Angina pectoris</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-5-84</u> to <u>2-23-84</u> that (I) (we) last saw the deceased alive on <u>2-22-84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Shaukat Y. Khan</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-23-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHAUKAT Y. KHAN				22e. ADDRESS 1528 King William Drive, Balt, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-27-84		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive		23d. LOCATION CITY OR TOWN COUNTY STATE Pimbalstown Balt. MD			
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, MD		25a. DATE REC'D. BY REGISTRAR 2/28/84		25b. REGISTRAR'S SIGNATURE Salie Swales-Randall	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or his authorized representative must be called and advised.

BP

DHMM - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.					
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES N. BURTSCHER						2a. DATE OF DEATH MONTH DAY YEAR 2 24 84				2b. HOUR 2:25A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 10, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR			12b. KIND OF BUSINESS OR INDUSTRY GAS & ELECT.CO.		
13a. STATE MD.						13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 812 HATHERLEIGH RD. 21212											
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES L. BURTSCHER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 212-05-3519		17. INFORMANT ADDRESS NANCY L. BRUST 812 HATHERLEIGH RD. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Anoxia</i> 2041 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Lymphatic Leukemia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>10 yrs</i> <i>54 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1 July 1948</i> to <i>24 Feb 1984</i> , that <i>we</i> saw the deceased alive on <i>20 February 1984</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>(I)</i> <i>(we)</i> <i>(did)</i> <i>(did not)</i> view the body after death.											
22b. SIGNATURE <i>Charles F. O'Donnell</i>						22c. ADDRESS 7501 YORK RD.			22d. DATE SIGNED <i>2/26/84</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						23b. DATE FEB. 27, 1984		23c. NAME OF CEMETERY OR CREMATORY MOST HOLY REDEEMER		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212						25a. DATE REC'D BY REGISTRAR FEB 28 1984					
						25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

MEDICAL CERTIFICATION



RECEIVED  
JUN 10 1964

APR 10 1964

OFFICE OF THE ATTORNEY GENERAL

STATE

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ATTORNEY

GENERAL

STATE OF

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GENERAL

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*[Handwritten signature]*

RECEIVED

ATTORNEY

STATE

DEPT.

RECEIVED

ATTORNEY

GENERAL

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

DHMH - 16 50M 4/83  
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
MARGARET BUTZ				FEBRUARY 19 1984 5:45A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS	
FEMALE		WHITE		10 29 28		55 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		USA				BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ROSSVILLE		FRANKLIN SQUARE HOSPITAL		Housewife		Homemaking-Langs Pickles	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
MARYLAND		BALTIMORE				13e. STREET ADDRESS / ZIP CODE	
						8120 Walnut Ave. 21237	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Edward Frederick Greaver				Irene Lockner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				213-26-0072		Nelson Butz 8120 Walnut Ave. 21237	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC and SEPTIC SHOCK</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> <u>CHRONIC RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 18 19 84, to FEBRUARY 19 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on FEBRUARY 19 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Irene F. Ibarra, M.D.</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>IRENE F. IBARRA</u>				22e. ADDRESS <u>9000 Franklin Square Drive 21237</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		2-22-84		Gardens of Faith		Baltimore Maryland	
24. FUNERAL DIRECTOR NAME <u>Lasson FH</u> ADDRESS <u>7101 Belair Rd</u> CITY <u>BALTIMORE</u> STATE <u>MD</u>				25. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

FEB 24 1984

TO : 55 50 05 04

FROM : 55 50 05 04

DATE : 55 50 05 04

TIME : 55 50 05 04

REF : 55 50 05 04

FEB 24 1955  
LTD 24 1955

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03330

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY</b> <b>Brigid</b> <b>BYRNES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 8, 1984</b>		2b. HOUR <b>11 55 AM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 28, 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food Preparer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Servimotion</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick McGrath</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Hastings</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-22-4402</b>		17. INFORMANT ADDRESS <b>Maggie Madden 3826 Tudor Arms Ave. 21211</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5560 Probable Hypovolemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Blood Loss, acute &amp; Chronic</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic ulcerative colitis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Chronic duodenal ulcer; Scleroderma</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1-23 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1-23 19 84</b> to <b>2-8 19 84</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>2-8 19 84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Samuel O'Mansky</b>		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMUEL O'MANSKY, M.D.</b>	
22e. ADDRESS <b>7620 York Road Towson Md 21204</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			
23b. DATE <b>Feb. 11, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>		24b. ADDRESS <b>6500 York rd.</b>		25. DATE REC'D. BY REGISTRAR <b>FEB 16 1984</b>	
25a. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, it shows only injury, or other traumatic event, the medical examination must be conducted promptly.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 3 3 1

36  
FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OF PRINT) JANE Sterner CAMERON			2a. DATE OF DEATH MONTH DAY YEAR 02/26/84			2b. HOUR 4:15AM						
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 01/19/15		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 33 Abigail La. 21901			
14. FATHER'S NAME FIRST MIDDLE LAST John Henry Sterner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Abigail Jackson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-38-4950		17. INFORMANT ADDRESS 75 Abigail La. North East, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC OAT CELL CA</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>84</u> , to <u>2/26</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2/26</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If signed, I will view the body after death.)												
22b. SIGNATURE <u>J. Washington Foote</u> , MD						DEGREE MD			22c. DATE SIGNED 2/26/84		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) DR. J. WASHINGTON-FOOTE						22e. ADDRESS GBMC--6701 N. CHARLES STREET						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 2-27-84		23c. NAME OF CEMETERY OR CREMATORY Cratin & Ferris			23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Pa.				
24. FUNERAL DIRECTOR Crouch Funeral Home North East, Md.						25a. DATE REC'D. BY REGISTRAR MAR 01 1984						
25b. REGISTRAR'S SIGNATURE <u>J. Washington Foote</u>												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified of this.

MEDICAL CERTIFICATION

BP

DATE: 4

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RECEIVED

NAME



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STANDARD UNIT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

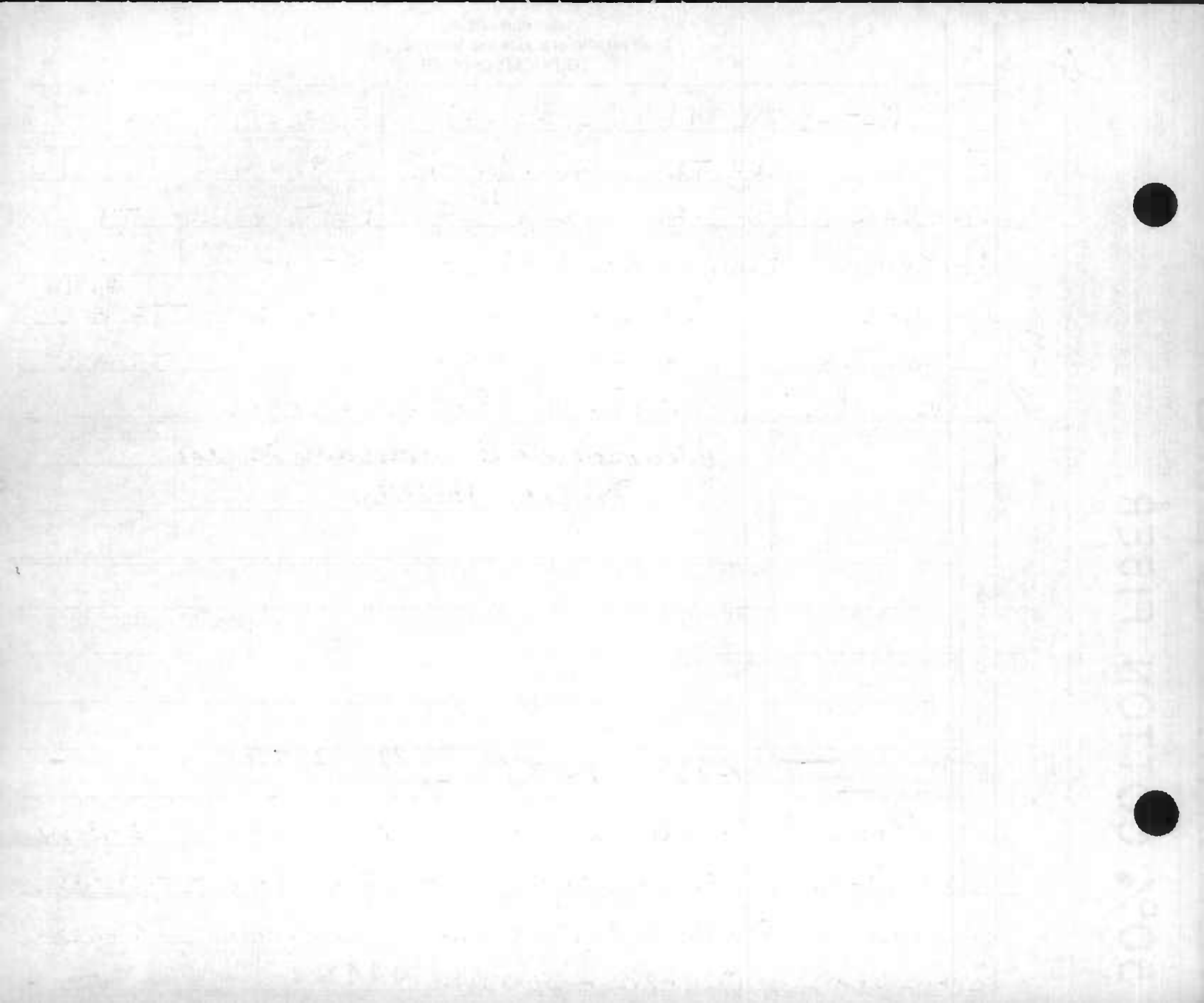
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 specify the time within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LATHSRINZ M. CAMPEGGI</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 9 1984</b>		2b. HOUR M <b>11</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 24, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10 CITY OR TOWN OF DEATH <b>PARKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>PERRING P.K.W. &amp; N. HOME</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AT HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SYLVESTER HOGAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA O'TOOLE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>215 32 2375</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the deceased) attended the deceased from <b>June 19 77</b> to <b>2-9-84</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>1-26</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Marion C. Kowalski MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>2-13-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. MARION C. KOWALSKI</b>				22e. ADDRESS <b>8604 HARFORD ROAD - PARKVILLE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>FEB. 13, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NAT.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPLAIN MEMORIALS</b>				ADDRESS <b>8800 HARFORD ROAD</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>			

BP \_\_\_\_\_





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03333

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Bertha</b> <b>CANARY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 2, 1984</b>			2b. HOUR <b>9:50 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 21 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Sq. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex 21221</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Schriener</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Weigan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213 05 6586</b>		17. INFORMANT ADDRESS <b>Leroy Canary, Husband</b> <b>Same</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
**Carcinoma Lung**

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

1629  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 28, 1983</b> , to <b>February 2, 1984</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>February 2, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> did not witness the body after death.							
22b. SIGNATURE <i>Myo Thant</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/2/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Myo Thant, M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/6/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION <b>Baltimore Co., Md.</b> STATE	
24. FUNERAL DIRECTOR <i>James J. Bruzdinski</i> <b>Bruzdinski Funeral Home PA</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 3 - 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03334

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph L. CANIFF			2a. DATE OF DEATH MONTH DAY YEAR February 3, 1984		2b. HOUR 12:55 a.m.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR APRIL 15 1908	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN	12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL	
13a. STATE MD.		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 210 LESLIE AVE. 21236
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD CANIFF		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY JANE HAMILTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 232-03-7533	17. INFORMANT ADDRESS 10 F Spindrift Circle PATRICIA BIANCONI (DGHTR) 21234		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Arrest

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Three Myocardial Infarctions

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a

S/P Pulmonary Edema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from January 15, 1984, to February 3, 1984, that (we) last saw the deceased alive on February 3, 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.			
22b. SIGNATURE L. Albiol	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 2-3-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Loreto Albiol	22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 2/6/84	23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR Schimunek Funeral Home Inc. 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR FEB 7 1984 25b. REGISTRAR'S SIGNATURE John J. Caniff	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03335

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		9:05pm	
Perry Greene CARROLL		February 20, 1984			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Male	White	MONTH DAY YEAR	62	IF UNDER 24 HRS	
		5 10 21		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
N. Carolina	U.S.A.		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
ESSEX	FRANKLIN SQUARE HOSPITAL				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
Maryland			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		340 East 25th St. 21218	
Green Carroll		Fancy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		238-22-7965		Iris Carroll 430 East 25th Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY.					
IMMEDIATE CAUSE (a) Acute And Chronic Necrotizing					
Pneumonia Complicating Severe Chronic Obstructive					
Pulmonary Disease					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from December 17, 19 83, to February 20, 19 84, that (we) last saw the deceased alive on February 20, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (do) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. DATE SIGNED	
M. Anderson, M.D.		9000 Franklin Square Drive 21237		2/20/84	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		2/25/84		New Cathedral Cem	
				Baltimore, Md.	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		FEB 23 1984			
Wm C March F/H Inc, 1101 E North Avenue					

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REF.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELMER E. CASSIDY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEB. 18, 84</b>			2b. HOUR <b>10<sup>10</sup> AM</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 21 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Night Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Std. Oil</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Cassidy</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Munzer</b>			13e. STREET ADDRESS / ZIP CODE <b>423 Dumbarton RD - 21212</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>212-09-0139A</b>		17. INFORMANT ADDRESS <b>Mrs. Theresa M. Cassidy 423 Dumbarton Rd. 21212</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Pulmonary Apoplexy 20</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Vascular Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 Hr</b> <b>7 dg</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>2-6-</b> 19 <b>84</b> , to <b>2-18-</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-18-</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Bernard S. Karpers Jr. M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/18/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD S. KARPERS JR. M.D.</b>			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 22/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cemt.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld</b> ADDRESS <b>6500 York Rd.</b>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 23 1984 Julia Davidson-Randall</b>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03337

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARIE Anna CATE</b>			2a. DATE OF DEATH MONTH <b>FEB</b> DAY <b>20</b> YEAR <b>84</b> 2b. HOUR <b>6:10AM</b> MIN <b>M</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>CAU</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>22</b> YEAR <b>07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.
10. CITY OR TOWN OF DEATH <b>TOWSON, MD.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Lutherville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>Earl</b> MIDDLE <b>Gordon</b> LAST <b>Bennett</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Elizabeth</b> MIDDLE <b>Winter</b> LAST <b>Winter</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>215-28-8635</b>		17. INFORMANT <b>Lucius C. Cate - Same as #13e</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBROVASCULAR ACCIDENT</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>10 YRS.</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>2/04</b> , 19 <b>84</b> , to <b>2/20</b> , 19 <b>84</b> , then (I) (we) last saw the deceased alive on <b>2/20</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Kenneth D. Byerly</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/20/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH D. BYERLY, MD.</b>		22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2-22-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium, Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

FEB 20 04:10AM

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78

LITMORE COUNTY

U.S.A.

Maryland

Own Home

Horseman

6210-6711 W. CHURCH ST.

TOMSON, W.

415 Fox Chapel Dr. - 21093

x

Indianville

Baltimore

Maryland

Winter

Missbach

Barnett

Gordon

Earl

Lucius O. Cato - Same as #136

215-18-6635

No

3 DAYS

SPARATION PNEUMONI

10 YRS.

CEREBROVASCULAR ACCIDENT

XX

2/27

84

2/24

X

XX

84

2/27

XXX

X

2/22/84

6210-6711 W. CHURCH ST.

KENNETH C. EVERLY, JR.

Thornton, Baltimore, Maryland

Dulaney Valley

2-22-84

Burial

1050 York Rd.

Back Tomson Funeral Home, Inc. Tomson, Md. 21094

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03338

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE HOPKINS CAUSEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 23, 1984</b>			2b. HOUR M <b>M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 27, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>82 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MULTI-MEDICAL CENTER, TOWSON</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>ENGINEER</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>COMBUSTION</b>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>TOWSON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>8031 YORK RD. 21204</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN E. CAUSEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADELINE HOPKINS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-07-7188</b>		17. INFORMANT ADDRESS <b>JESSIE W. CAUSEY 8031 YORK RD. APT. B8 21204</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

2900

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/19/84</u> to <u>2/24/84</u> , that (I) (we) last saw the deceased <u>live</u> <u>above</u> , (I) (we) (did) (did not) <u>view the body after death</u> , and that (I) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <i>[Signature]</i>		22c. DATE SIGNED <b>2/24/84</b>				22d. TENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>FEB. 27, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY MEM. GDNS. COCKEYSVILLE BALTO. MD.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1984</b>			
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED

100

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100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST FRANK J. CAWLEY			MONTH DAY YEAR 2 2 84			2000 M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
MALE	WHITE	MONTH DAY YEAR 9/23/1901	82 YRS.	MONTHS DAYS	HOURS MIN.	2 3 19 84	1415 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
MD.			USA.			BALTO COUNTY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
DUNDALK			64 DUNDALK AVE 21222			CARPET MAN		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MD			BALTO			DUNDALK		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.		
FIRST MIDDLE LAST UNK			FIRST MIDDLE LAST UNK			217-07-3827		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			17. INFORMANT			18. CAUSE OF DEATH		
(YES, NO, OR UNKNOWN) NO			(IF YES, GIVE WAR OR DATES) -			EVELYN MALCZEWSKI 7801 MEATH RD. 21222		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED		
21d. INJURY OCCURRED WHILE AT WORK			21e. PLACE OF INJURY			21f. LOCATION		
22a. I certify that I took charge of the remains described above, held on death resulted from:			22b. DATE			22c. NAME OF CEMETERY OR CREMATORY		
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			2/6/1984			ST. STANISLAUS		
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
BURIAL			2/6/1984			ST. STANISLAUS		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
NAME ADDRESS CONNELLY FUNERAL HOME OF DUNDALK			FEB 7 1984			John J. Cawley		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a)

Acute myocardial infarction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion

ACTUAL SIGNATURE

J. Crossan O'Donovan

M.D.

Deputy

MEDICAL EXAMINER

DATE SIGNED

2/3/84

EXAMINER'S NAME (TYPE OR PRINT)

J. CROSSAN O'DONOVAN

ADDRESS

2112 Dundalk Ave., Balto., Md. 21222

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

23b. DATE

2/6/1984

23c. NAME OF CEMETERY OR CREMATORY

ST. STANISLAUS

23d. LOCATION CITY OR TOWN

BALTO

STATE MD.

24. FUNERAL DIRECTOR

NAME

ADDRESS

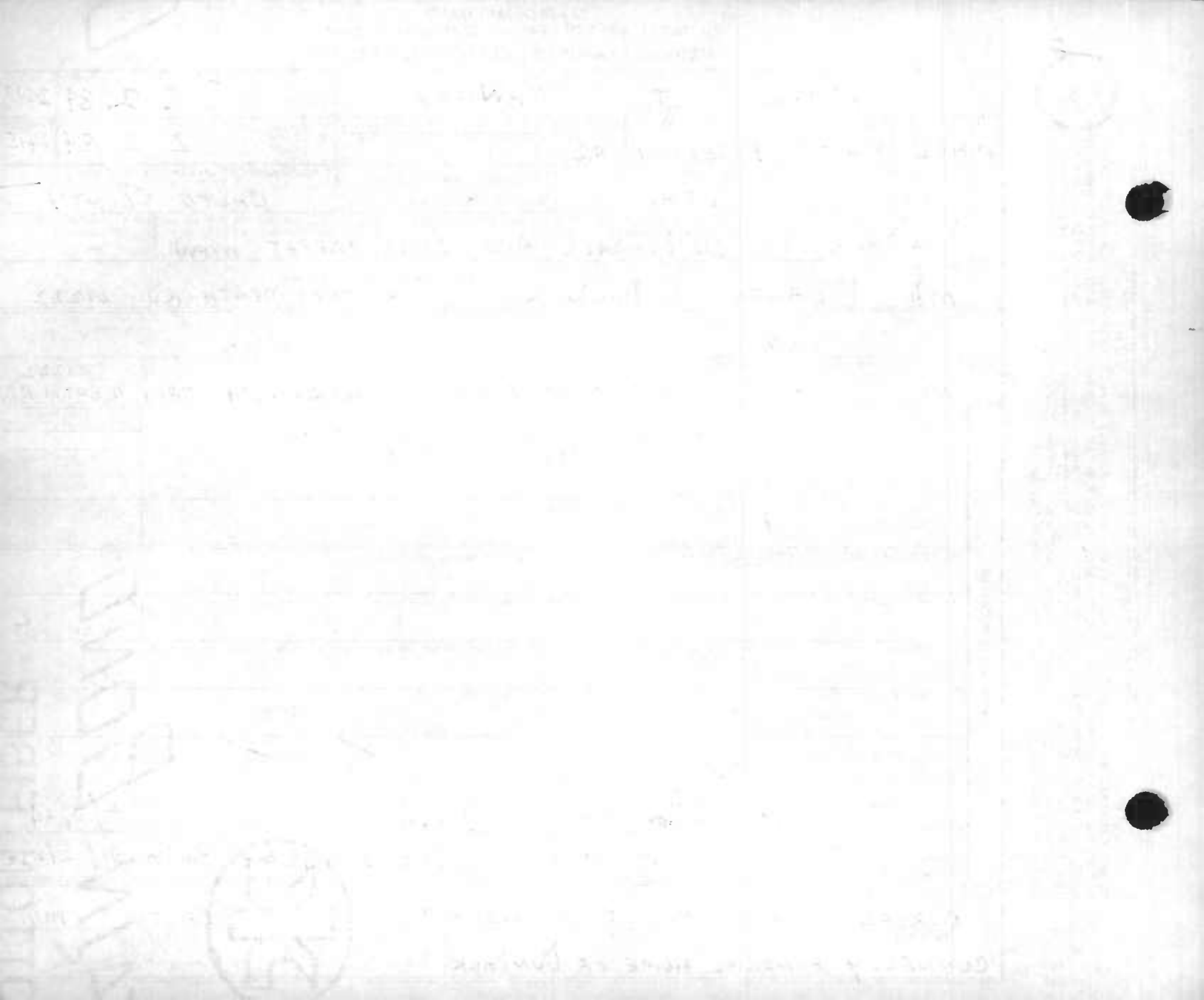
CONNELLY FUNERAL HOME OF DUNDALK

25a. DATE REC'D. BY REGISTRAR

FEB 7 1984

25b. REGISTRAR'S SIGNATURE

John J. Cawley



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Roberta Mary Cawley</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>February 4, 1984</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 21, 1946</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>37</b>		
10. CITY OR TOWN OF DEATH <b>Cockeysville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2 High Pine Court, Cockeysville</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Cockeysville</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Hall</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Betty Way</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>194-38-9971</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic colon cancer</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>September 1983</b> to <b>February 1984</b> , that (I) (we) last saw the deceased alive on <b>January 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.						
22b. SIGNATURE <b>Georgia Vogelsang</b>		DEGREE		22c. DATE SIGNED <b>Feb 84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Georgia Vogelsang, M.D.</b>		22e. ADDRESS <b>600 N. Wolfe St.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>		23b. DATE <b>Feb. 7, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory Catonsville, Balto., Md.</b>		
24. FUNERAL DIRECTOR <b>Lemmon-Mitchell-Wiedefeld</b>		ADDRESS <b>10 W. Padonia Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 7 1984</b>		
				25b. REGISTRAR'S SIGNATURE <b>John J. Lohr</b>		

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
RUTH BEVERLY CHAMBERLIN			February 20, 1984			4:00a.m.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	White	October 26, 1915	68			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania	U.S.A.		Baltimore County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson	Multi-Medical Center		Bank Teller & Nurse					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Pennsylvania			Willow Grove					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
Wellington B. Searls			Amy Giles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			213-42-3751			Willow Grove, Pa. W.A. Chamberlin- 1512 Berkley Pl. 19090		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Renal Failure</u>								
2500 DUE TO, OR AS A CONSEQUENCE OF								
(b) <u>Diabetes</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):								
<u>Multiple Cerebral vascular accidents</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION		
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1 JAN 19 80</u> to <u>20 FEB 19 84</u> , that (I) (we) last saw the deceased alive on <u>25 FEB 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Howard H. Bond</u>			<u>MD</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Howard H. Bond, M.D.			9618 Belair Rd. Balto., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			2-22-84			Druid Ridge		
24. FUNERAL DIRECTOR NAME			ADDRESS			23d. LOCATION (CITY OR TOWN) COUNTY STATE		
Ruck Towson Funeral Home, Inc. Towson, Md. 21204			1050 York Rd.			Pikesville Maryland		
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE		
FEB 23 1984						<u>G. J. ...</u>		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03342

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DOROTHY L CHANNER			2a. DATE OF DEATH MONTH DAY YEAR 2 6 84			2b. HOUR 11 55 AM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5 2 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. Co. Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Balto. Co.	
13a. STATE md				13b. COUNTY Balto		13c. CITY OR TOWN Pikesville	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Leavitt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Calista Maude Morrill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 073-16-7428		17. INFORMANT ADDRESS R. John Channer 1316 Witherspoon Dr., Thousand Oaks, Calif.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a).

5860

DUE TO, OR AS A CONSEQUENCE OF.

(b) SEPSIS

DUE TO, OR AS A CONSEQUENCE OF

(c) RENAL FAILURE

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-5-19-84, to 2-6-19-84, that (I) (we) last saw the deceased alive on 2-6-19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. DEPESTRE				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. DEPESTRE				22e. ADDRESS BALTIMORE COUNTY GENERAL HOSP.			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		23b. DATE Feb. 8, 1984		23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Keisterstown Balto. Md.	
24. FUNERAL DIRECTOR H. E. Ehlhardt				ADDRESS Owings Mills, Md.		25. REGISTRAR'S SIGNATURE FEB 09 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FILE

CHAMBER

CHAMBER IS ITSELF BY ADVERT

FEBRUARY 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Margaret Charbonnet</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>2/26/84</i>		2b. HOUR <i>11:40</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>08-01-04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>79</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Marrow Care Nursing Home</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <i>MD</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Joppa</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Benjamin F. Eilers</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sally Louise Humphreys</i>		16. STREET ADDRESS <i>146 Crestview Road 21085</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-07-0201</i>		17. INFORMANT <i>Yvonne Humphreys</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Cardiopulm. Arrest*  
*5860*  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
(b) *Severe Renal Failure*  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

*AscVD, Cerebrovascular dis.*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>2/24</i> 19 <i>84</i> , to <i>2/27</i> 19 <i>84</i> , that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A. Haroun</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2.27.84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Haroun</i>		22e. ADDRESS <i>Romville Manor Care, Bldg. No. 21237.</i>					

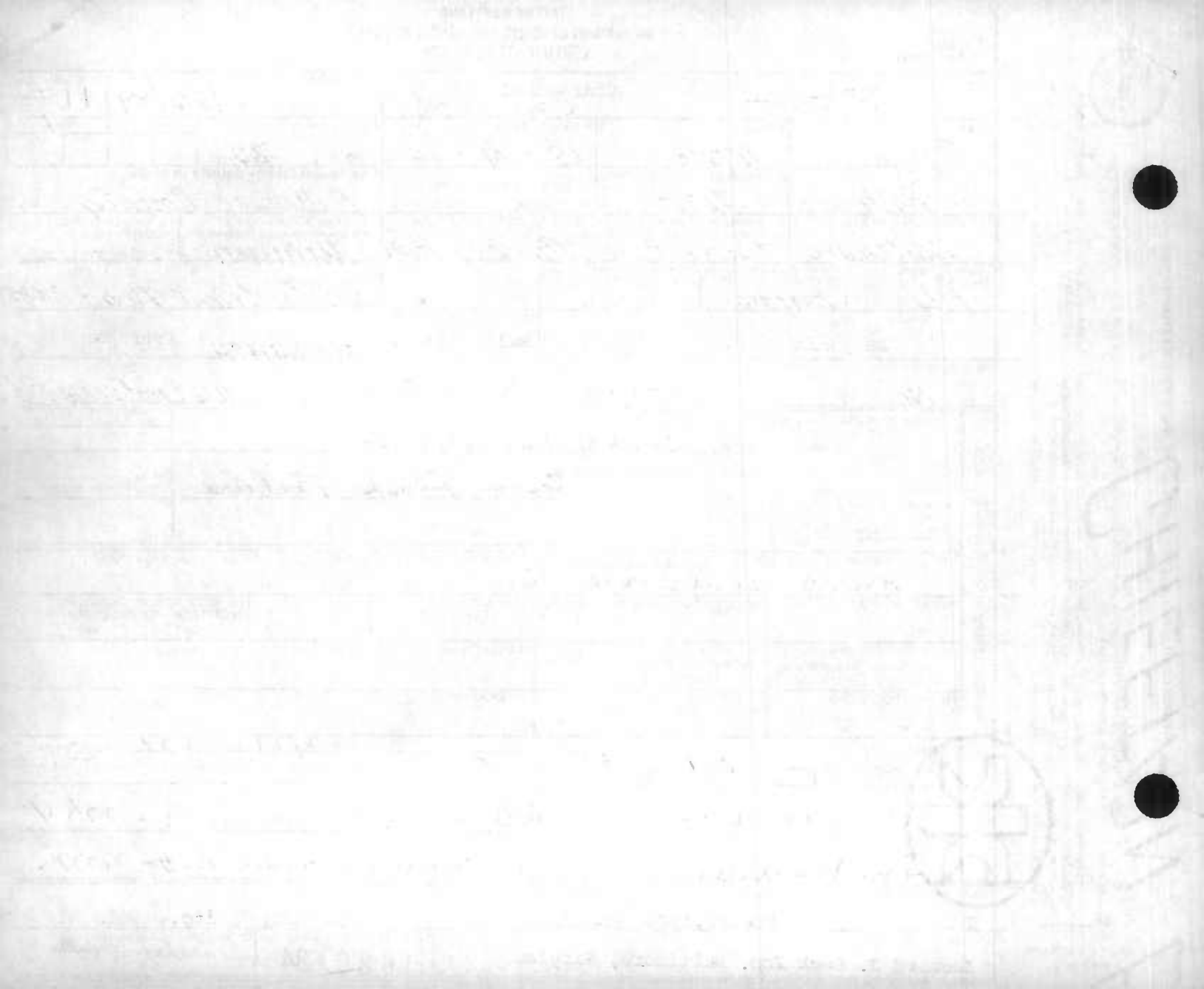
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Feb. 29, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Balto. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck Inc. Baltimore, Maryland</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 28 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Bernard A. CHASE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>February 6, 1984</b>		2b. HOUR <b>9:58am</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 24 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Western Electric</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur P. Chase</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Dietz</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>8227 Longpoint Rd. Katherine R. Chase - Balto. MD 21222</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: <b>Disseminated Carcinoma</b> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ <b>1991</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) this hospital attended the deceased from <b>January 6, 1984</b> to <b>February 6, 1984</b> , that (X) (we) last saw the deceased alive on <b>February 6, 1984</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.									
22b. SIGNATURE <b>Jagiello MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>2/6/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ben Jagiello, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/9/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Avenue, Dundalk, MD 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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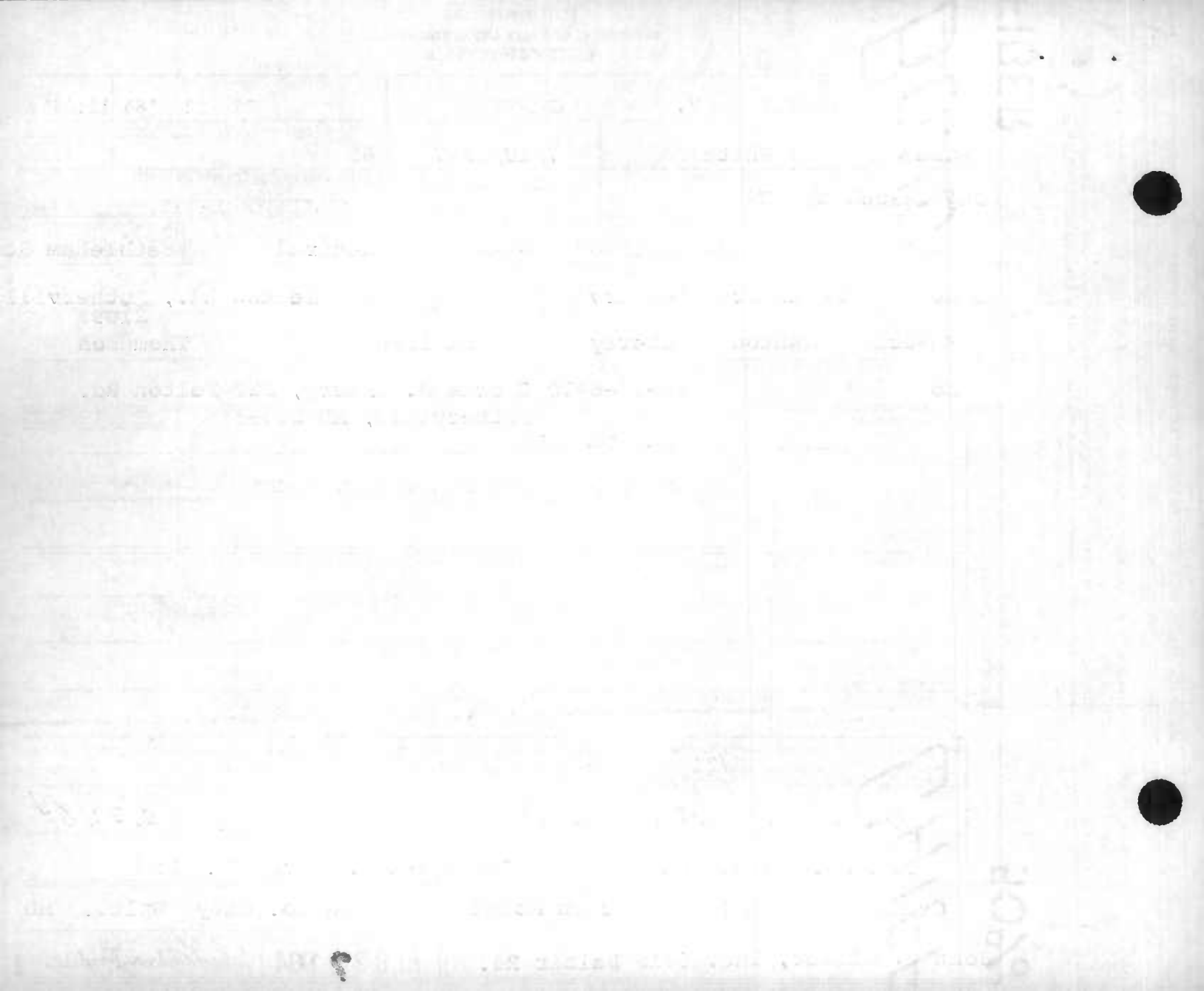
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										03345	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JEROME V. CHERRY					2a. DATE OF DEATH MONTH DAY YEAR 02 22 '84			2b. HOUR 12:45 <sup>P</sup> M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7/18/1917		6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Long Island NY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY, MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREATER BALTIMORE MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Bethlehem St.			
USUAL RESIDENCE (IE NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD					13b. COUNTY Baltimore		13c. CITY OR TOWN Lutherville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Ashton Cherry					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Thompson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 055-14-8470		17. INFORMANT ADDRESS Gloria M. Cherry, 220 Felton Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE METASTASIS LARYNGEAL CANCER DUE TO, OR AS A CONSEQUENCE OF (c) 1619										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 02/15, 19 84, to 02/22, 19 84, that (I) (we) last saw the deceased alive on 02/22, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael W. Robley M.D.				DEGREE M.D.				22c. DATE SIGNED 2/22/84		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL W. ROBLEY, M.D.				22e. ADDRESS GBMC - 6701 N. CHARLES ST. 21204							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 2/25/84		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION BALTO. CITY COUNTY BALTO. STATE MD			
24. FUNERAL DIRECTOR NAME John C. Miller, Inc. 6415 Belair Rd.						25a. DATE REC'D. BY REGISTRAR FEB 27 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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FOR  
1- STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR			
DAVID CHRISTOPHER CZYZ			2-3-84 19			M			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED	10. HOUR		
Male	White	Sept 8, 1959	24 YRS.			3-17-84 19	8:30A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.			Baltimore County MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Essex			Seneca Creek@Strawberry Pt.			Paper Delivery			
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS			
Maryland			Baltimore Co			3939 New Section Rd 21220			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Conrad E Cxyz			Theresa J Varinski						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			214-72-6276			Conrad E Cxyz Same As 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9108 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.									
Narcotism									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
			? P.M. 2-?-84 19		subject found in water				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION				
			creek		Seneca Creek@Strawberry Pt. Essex, Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED			
Margarita A. Korell, M.D.			Assistant			3-17-84			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS						
Margarita A. Korell, M.D.			111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial			3/20/84		Dulaney Valley		Baltimore, Maryland		
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J Ruck Inc. Baltimore, Maryland						MAR 20 1984		Lelia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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RECEIVED

UNITED STATES



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Domenico</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>February 7, 1984</b>					2b. HOUR <b>9:30 P. M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 4 83</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>101</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6538 Saint Helena Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Exxon Corp.</b>			
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cimaglia</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>6538 St. Helena Ave. 21222</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. (IF YFS, GIVE WAR OR DATES) <b>214-01-4581</b>		17. INFORMANT ADDRESS <b>Mary Cimaglia 6538 St. Helena Ave. 21222</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>CACHEXIA</b> <b>7994</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>David P. Zajano MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>2-9-84</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID P. ZAJANO MD</b>	
22e. ADDRESS <b>FRANKLIN SQUARE HOSPITAL</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2-11-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk, Balto. Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Charles S. Zeiler &amp; Son Inc.</b>						ADDRESS <b>6224 Eastern Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 9 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 3 4 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Assunta			MIDDLE Dolores			LAST CITRO			2a. DATE OF DEATH MONTH DAY YEAR February 17, 1984			2b. HOUR 8:40pm M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 6 22 27			6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.								
10. CITY OR TOWN OF DEATH Rossville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife			12b. KIND OF BUSINESS OR INDUSTRY homemaking					
13a. STATE Maryland						13b. COUNTY Baltimore			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4321 Soth Avenue 21236		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Giordano						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette Schavio											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES no						16b. SOCIAL SECURITY NO. 219-22-9756			17. INFORMANT ADDRESS Louis J. Citro 4321 Soth Ave. 21236								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma of colon (c) Right lower lobe pneumonia DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: no												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (this hospital) attended the deceased from February 17, 19 84, to February 17, 19 84, that (we) lost saw the deceased alive on February 17, 19 84, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.												22b. SIGNATURE Daniel M. Jamuzzi, MD DEGREE		22c. DATE SIGNED 2/17/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel M. Jamuzzi, MD						22e. ADDRESS 9000 Franklin Square Drive, 21237											
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial			23b. DATE 2-20-84			23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.								
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home Balto., Md. 21236						25a. DATE RECD. BY REGISTRAR FEB 22 1984			25b. REGISTRAR'S SIGNATURE John Davidson-Randall								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "X", show any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1961

1000

20%

1000

4

Handwritten notes and markings, including "Handwritten" and "Handwritten" repeated.

Handwritten notes and markings, including "Handwritten" and "Handwritten" repeated.

Handwritten notes and markings, including "Handwritten" and "Handwritten" repeated.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 3 4 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mrs. Johanna V. Coggins</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 19 1984</b>			2b. HOUR <b>8<sup>39</sup></b> M.				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 7 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Pikesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>216 Oak Avenue</b> 21208	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Flohr</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Fuhrman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-74-0957</b>		17. INHABITANT ADDRESS <b>Mr. Claude W. Coggins Sr.</b>		21208 <b>Pikesville Maryland</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Probable wrosepis</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>1d</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (i) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I have) (I did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregory A. McAniff, MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-19-84</b>	
22d. ADDRESS <b>Baltimore Co Gen Hosp Randallstown Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>02-22-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc.</b> <b>8728 Liberty Road Randallstown, Maryland 21133</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
Lula		L.		(Cohen)		COHENS		2-19		19 84		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	Black	8 20 38		45 YRS.		MONTHS DAYS HOURS MIN.				2-19 19 84		10:07 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.		WIDOWED		DIVORCED		Baltimore County,				MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Randallstown		Baltimore Co. General Hospital											
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Maryland		Baltimore		YES X NO		102 Sunmar Court Apt. 2D							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Warren		Evelyn E. Thomas											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
UNKNOWN		218-42-1007		Elnora Green		1149 N. Calhoun Street							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Pulmonary Embolism, acute													
4151													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
Obesity													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
								CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection, Inquiry, and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Dennis F. Smyth, M.D.				Assistant				2-20-84					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Dennis F. Smyth, M.D.				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL				2/25/84		Mount Auburn Cem.				Baltimore, Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Wm C March F/H Inc.				FEB 21 1984				Julia Davidson-Randall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Billy Dale COLLETT					2a. DATE OF DEATH MONTH DAY YEAR February 6, 1984			2b. HOUR 9:35 P <sub>M</sub>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 1 1937		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 413 Lorraine Ave. 21221	
14. FATHER'S NAME FIRST MIDDLE LAST Blair Collett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Fawley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1960-1963				16b. SOCIAL SECURITY NO. 213-34-6535		17. INFORMANT Gloria A. Collett Same as Line 13e.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic and renal failure 5712 DUE TO, OR AS A CONSEQUENCE OF (b) Alcoholic cirrhosis, portal hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Cardiomyopathy - ascites									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from Jan. 3, 19 84, to Feb. 6, 19 84, that (we) last saw the deceased alive on Feb. 6, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. Montandon				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 2-6-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. MONTANDON				22e. ADDRESS Franklin Square Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/10/84		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford, MD		
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				ADDRESS 7922 Wise Avenue, Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph David COMER</b>			2a. DATE OF DEATH <b>February 5, 1984</b>		2b. HOUR <b>2:53A</b> <small>M</small>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>January 26, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Frederick Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rossville (21237)</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Artillery Repair Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Harford Co.</b>	13c. CITY OR TOWN <b>Churchville (21028)</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>2603 Palmyra Drive 21028</b>	
14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>Guy</b> LAST <b>COMER</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Emma</b> LAST <b>Blevins</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES-Army</b>		16b. SOCIAL SECURITY NO. <b>WW2 178-16-5773</b>		17. INFORMANT (WIFE) <b>Mrs. Darthey Rhodes Comer</b> ADDRESS <b>2603 Palmyra Drive Churchville, Maryland 21028</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4140 Cardiac Arrest</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Left main coronary artery disease</b> (c) <b>Aortic Valve disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>Aortic Stenosis/Aortic Insufficiency</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 30, 1984</b> to <b>February 5, 1984</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 5, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Joseph A. Schneider, M.D.</b>		DEGREE		22c. DATE SIGNED <b>2/5/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph A. Schneider, M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 7, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air, Harford Co., Maryland 21014</b>	
24. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>W. Broadway &amp; Williams St.</b> <b>Bel Air, Maryland 21014</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 07 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Comer</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.						
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
1. DECEASED NAME FIRST MIDDLE LAST AGNES M. CONNOR					February 25, 1984				5:00 P.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 16, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Timonium		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN INSANE ASYLUM, GIVE STREET ADDRESS) 225 Chantry Road				12a. USUAL OCCUPATION (TYPE OF WORK AT MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Towson					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 205 E. Joppa Road 21204				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph P. Grogan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachael Rattrey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 220-44-9793		17. INFORMANT ADDRESS 21093 Mrs. Eileen C. Spigelmire 225 Chantry Road				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Occlusive embolism</i> 1579 DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Intractable Carcinoma Pancreas &amp; Duodenum with Biliary duct obstruction</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>NO</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 to 4</i> <i>4-6+ hrs.</i>					PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>NO</i>						
19a. DATE OF OPERATION Dec 30 83					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED as above Obstruction			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR WHILE <input type="checkbox"/> AT HOME					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <i>12/1/83</i> to <i>Feb 25/84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (I) examined the body after death.					22b. SIGNATURE <i>Frank T. Kasik, Jr.</i>		22c. DATE SIGNED 2/28/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank T. Kasik, Jr; M.D.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 2-29-1984		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.					25a. ADDRESS 1050 York Road Towson, Maryland		25b. DATE REC'D. BY REGISTRAR FEB 28 1984		25c. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Mr. Daniel Conroy</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>February 1 1984</b>				2b. HOUR <b>5:53 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 10 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hughes Lumber</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Company</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <b>924 Prestwood Road 21228</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Daniel Conroy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret McConnell Conroy</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-05-7245</b>		17. INSURANCE ADDRESS <b>Mrs. Ruth Conroy 21228 924 Prestwood Road Catonsville Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>20 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-15-1984</b> , to <b>2-1-1984</b> , that (I) (we) last saw the deceased alive on <b>2-1-1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R.M. Shah MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>2-1-84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.M. SHAH</b>				22e. ADDRESS <b>Baltimore County General Hospital Randallstown, MD 21133</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>02-04-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Church</b>			
8728 Liberty Road Randallstown, Maryland 21133											

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WARNER E. CORAM</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>FEB. 28 1984</b>		2b. HOUR <b>9:14 A.M.</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 21 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ENGINEER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BALTO. CO. BOARD OF ED.</b>
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GUY CORAM</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FREIDA LONG</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW II 216-01-9020</b>		17. INFORMANT ADDRESS <b>DOROTHY CORAM (WIFE) SAME ADDRESS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediately</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>Long Standing Asthma</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>1-7</b> 19 <b>80</b> , to <b>2-28</b> 19 <b>84</b> , that (we) lost saw the deceased alive on <b>12-22</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>DR. GEORGE E. LOWE</b>		DEGREE <b>PHYSICIAN</b>		22c. DATE SIGNED <b>2/29/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>3703 BELAIR RD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>3/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BOHEMIAN NAT'L</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>		24. FUNERAL DIRECTOR <b>SCHIMUNEK FUNERAL HOME, INC.</b> <b>3331 Brehms Lane, Balto Md. 21213</b>			
25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

FOR  
STATE  
REGISTRAR

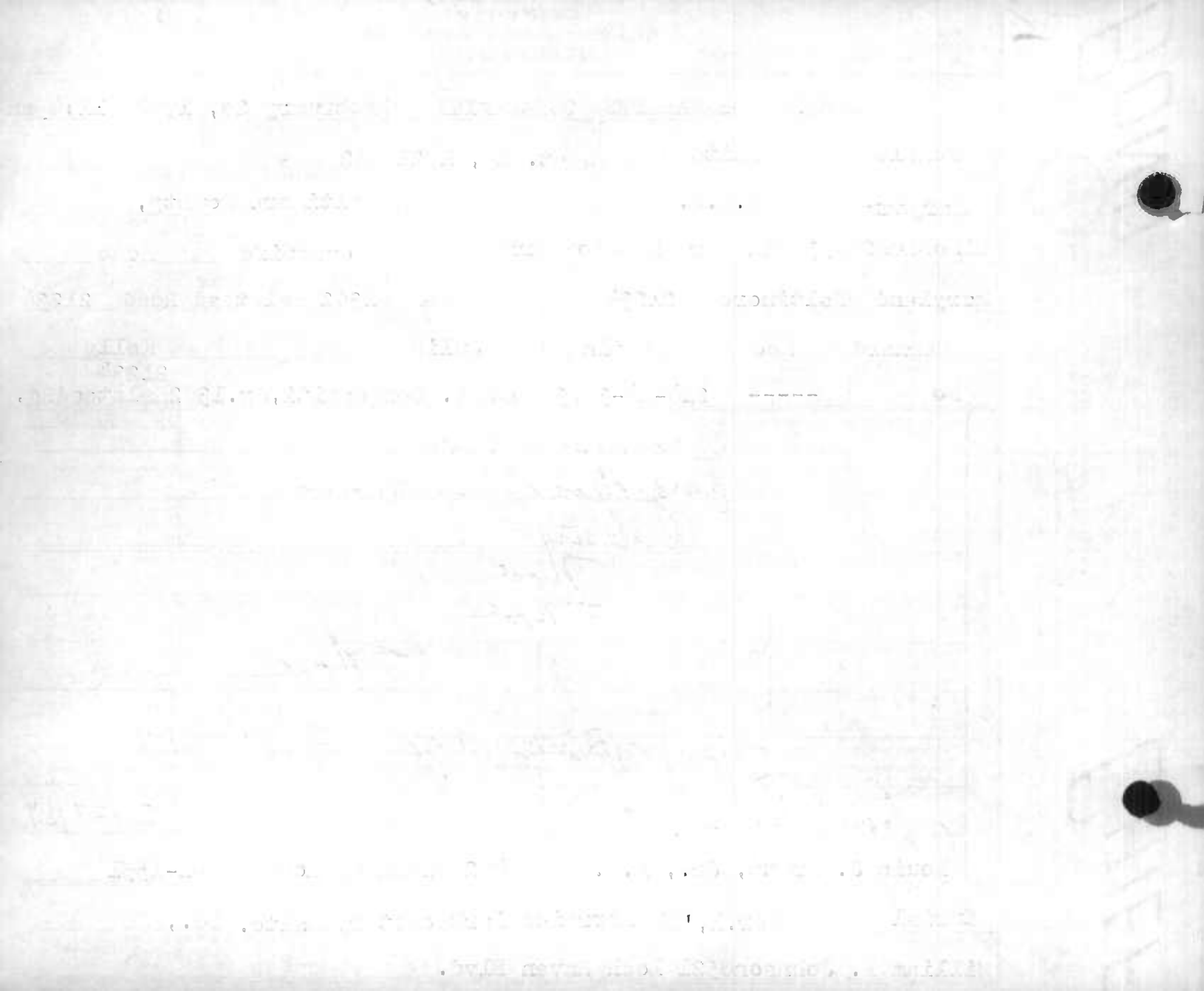
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL BERNADETTE CORASANITI</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 26, 1984</b>			2b. HOUR <b>11:45am</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 18, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Timonium 21093</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>110 Greenmeadow Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21234</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1302 Halstead Road 21234</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard Leo Martin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Kelly</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-----</b>		17. INFORMANT ADDRESS <b>21234</b> <b>John V. Corasaniti, Jr. 1302 Halstead Rd.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive C.V. disease</b> (c) <b>Obesity</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>None</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, MOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED, (IF NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>None</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/24/84</b> to <b>2/24/84</b> , that (I) (we) last saw the deceased alive on <b>2/24/84</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Louis J. Pratt, Jr.</b>			DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>2/27/84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louis J. Pratt, Jr., M.D.</b>			22e. ADDRESS <b>8402 Greenway Road 661-1551</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Mar. 1, '84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery Balto. Co., MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>			ADDRESS <b>8521 Loch Raven Blvd.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1984</b>			25b. REGISTRAR'S SIGNATURE <b>John Davidson-Russell</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Beatrice E. Countess</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 14 84</i>			2b. HOUR <i>8:01</i> M.			
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>10 19 07</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Valley View Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Harford</i> 13c. CITY OR TOWN <i>Abingdon</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>ABINGDON, MD. 21009 2913 Brightwater La.</i>			
14. FATHER'S NAME <i>Emil Mynar</i>				15. MOTHER'S MAIDEN NAME <i>Anna Zitnik</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>219-28-9905</i>		17. INFORMANT ADDRESS <i>Abingdon, Md. 21009 Delores Dolbow 2913 Brightwater La.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4860</i> IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Organic Brain Id</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9/23/81</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part I, or Part II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the physician) attended the deceased from <i>2/8/84</i> to <i>2/14/84</i> that (I) (the physician) saw the deceased alive on <i>2/8/84</i> and that in my opinion death occurred on the date and hour and from the causes stated above. (I) (the physician) did not view the body after death.									
22a. SIGNATURE <i>Vuont Nguyen</i>				DEGREE		22b. DATE SIGNED <i>2/15/84</i>			
22c. PHYSICIAN'S NAME <i>VUONT NGUYEN</i>				22d. ADDRESS <i>6331 Belair Rd Balto Md 21206</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-18-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto., Md.</i>			
24. FUNERAL HOME <i>Schunneker Funeral Home, Inc.</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 17 1984</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			
24a. ADDRESS <i>9705 Belair Road, Balto., Md. 21236</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>BERNARD JOSEPH COVAHEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>2/13/84</b>			
3. SEX <b>Male</b>				2b. HOUR <b>6:40P<sup>M</sup></b>			
4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 26, 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N CHARLES ST GBMC</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Crane Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Copper &amp; Brass</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Joseph Covahey</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie E. Lohr</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>220 22 2636</b>		17. INFORMANT ADDRESS <b>Leonard J. Covahey 1241 Union Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>BRAIN DEATH 2<sup>0</sup></b> <b>4274</b> IMMEDIATE CAUSE (a) <b>VENTRICULAR FIBRILLATION</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>FEB. 8</b> , 19 <b>84</b> , to <b>FEB 13</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>FEB 13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Barbara D. Conley</i> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/13/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR B. CONLEY</b>				22e. ADDRESS <b>GBMC</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>02-16-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest Vet.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Garrison, Balto Co., Md</b>	
24. FUNERAL DIRECTOR <b>Burgee Funeral Home, Baltimore, Maryland</b>				25a. DATE REGD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 15 1984</b>			

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STATE OF MARYLAND

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FOR  
1 - STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE F. COVER</b>			2a. DATE OF DEATH MONTH <b>2</b> DAY <b>7</b> YEAR <b>84</b>			2b. HOUR M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>1</b> YEAR <b>18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Multi Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Repairs</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Tool</b>	
13a. STATE <b>80 Md.</b>		13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>801 Winters Lane 21228</b>	
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Milton</b> LAST <b>Cover</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Frances</b> MIDDLE <b>Cordelia</b> LAST <b>Shields</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT ADDRESS <b>7906 Oakwood Rd. Glen Burnie, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Insufficiency</b> <b>2028</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Radiation fibrosis &amp; COPD and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recurrent Pneumonia</b> <b>Mixed Lymphoma in Mediastinum</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mon.</b> <b>3 mon.</b> <b>6 mon.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>10</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>84</b> CITY OR TOWN <b>84</b> COUNTY <b>84</b> STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>Jan 17 1984</b> to <b>Feb 7 1984</b> , that (1) (we) lost saw the deceased alive on <b>Jan 17 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles Padgett</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/8/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES PADGETT</b>				22e. ADDRESS <b>5601 Loch Raven Blvd.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>2/7/84</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>				ADDRESS <b>Balto., Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>Feb 22 1984</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) MILORED C. COWARD				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 17 1984		2b. HOUR 6 AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 27 1899		6. AGE (IN YEARS LAST BIRTHDAY) 84
7a. BIRTHPLACE (COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1223 Southview Rd 21218
14. FATHER'S NAME FIRST MIDDLE LAST Frederick J. Turner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Brown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213 74 8807		17. INFORMANT ADDRESS C. Clifton Coward Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2-5 19 84, to 2-17 19 84, that (he) (we) lost saw the deceased alive on 2-17 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.						
22b. SIGNATURE <u>Beatriz P. Dizon, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/17/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Beatriz P. Dizon, M.D.				22e. ADDRESS 7620 York road towson MD. 21204		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/20 1984		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cent		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Rd.				25a. DATE REC'D. BY REG. 1984 FEB 21 1984		
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "JAN 1941" are faintly visible.]*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY C. CRAIG</b>				20. <b>FEBRUARY 7, 1984</b>			
3. SEX <b>FEMALE</b>				2b. HOUR <b>11:30AM</b>			
4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 6, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MANOR CARE, TOWSON RUXTON</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>				13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CLARENCE CALLERY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DRUCILLA ROBSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-24-8131A</b>		17. INFORMANT ADDRESS <b>WILLIAM M. CRAIG 26B LAMBOURNE RD. 21204</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Arteriosclerotic Cardio-vascular disease</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Insulin dependent diabetes mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this office) attended the deceased from <b>Feb 16 1984</b> to <b>7 Feb 1984</b> , that (I) (we) last saw the deceased alive on <b>Feb 16 1984</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) see the body after death.							
22b. SIGNATURE <b>Marc I. Leavey, M.D.</b>				22c. DATE SIGNED <b>7 Feb 84</b>		22d. ADDRESS <b>7600 Osler Drive Towson MD 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>FEB. 11, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY MEM. GDNS. COCKEYSVILLE BALTO. MD.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDE FELD HOME 6500 YORK RD. 21212</b>				25. DATE REC'D BY REGISTRAR 25a. REGISTRAR'S SIGNATURE <b>FEB 16 1984 Julia Davidson-Rendell</b>			

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Insulin dependent diabetes mellitus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY A CRANSTON			2a. DATE OF DEATH MONTH DAY YEAR 2 17 84		2b. HOUR 9:35a M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 17, 1896	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Rhode Island	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH County (Balto.) MD		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY Balto.	13c. CITY OR TOWN Lutherville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST James Schofield			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Hilton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212 30 3529	17. INFORMANT ADDRESS Mrs. Dorothy Fitzgerald, Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4850 Confluent Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) A.S.C.V.D.; Diverticulitis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/14, 19 84, to 2/17, 19 84, that (I) (we) last saw the deceased alive on 2/17, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Breitenecker		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/17/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rudiger Breitenecker		22e. ADDRESS 6701 N. Charles St. Balto., MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/20/84	23c. NAME OF CEMETERY OR CREMATORY Fork United Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE Fork, Harford Co., MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. 4905 York Road Balto., MD 21212		25a. DATE REC'D. BY REGISTRAR FEB 21 1984		25b. REGISTRAR'S SIGNATURE R. Davidson-Randall	

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## Introduction

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Mr. Dorothy Fitzgerald



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For more information, contact:

70774, 70775

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State of New York, County of Albany, ss. I, the undersigned, a Notary Public in and for said County, do hereby certify that the foregoing is a true and correct copy of the original of the same, as the same appears from the records of said County.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03363

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT GLENN CRUSH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2/1/1984</b>		2b. HOUR <b>3:00</b> <sup>A</sup>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 24 1901</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DULANEY TOWSON NURSING CENTER</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELECTRICAL ENGR.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>WESTINGHOUSE</b>			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>TOWSON</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE W. CRUSH</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET PARKER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215.07.3837</b>		17. INFORMANT <b>ROBERT G. CRUSH, JR. (SAME AS 13E)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>3320</b> IMMEDIATE CAUSE (a) <b>CARDIO pul. Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized cachexia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PARKINSON'S Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>YRS</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>BPH, chronic U.T.I., Senility</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>9-16</b> , 19 <b>74</b> , to <b>2-1</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>1-25</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>SIDNEY J. VENABLE</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>2-1-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SIDNEY J. VENABLE, M.D.</b>		22e. ADDRESS <b>7215 YORK ROAD BALTIMORE, MD 21212</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>2/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREEN MOUNT CEMETERY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 2 1984</b>				
24. FUNERAL DIRECTOR NAME <b>WALTER BROOKS BRADLEY, INC. BALTO., MD 21222</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

LIBRARY

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MICHIGAN LIBRARY  
ANN ARBOR, MICHIGAN



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03364

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN LUBA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 19, 1984</b>		2b. HOUR <b>3:10 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 11, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>1</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>PARKVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8823 OLD HARFORD ROAD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMP.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>ICE MAN</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>PARKVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>8823 OLD HARFORD ROAD 21234</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218 01 6035</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1850 IMMEDIATE CAUSE (a) Adenocarcinoma of prostate</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2+ years</b>
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Metastases to liver</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>None</b> 19 <b>84</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>None</b>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>None</b>	21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>None</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>1981</b> , 19____, to <b>Feb 19</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Feb 15</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles E. Ellicott MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>20 Feb 1984</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. CHARLES E. ELICOTT</b>		22e. ADDRESS <b>1134 YORK ROAD - LUTHERVILLE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>FEB. 22 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEM. PK.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PARKVILLE BALTO. MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPLAIN OF MEMORIES</b>		ADDRESS <b>8800 HARFORD RD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked either "B" or "C" indicating any injury, or other traumatic event, the medical examiner must be notified immediately.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03365

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARGIE C MIDDLE LAST Cunningham			2a. DATE OF DEATH MONTH DAY YEAR 02 15 1984		2b. HOUR 7:45 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05 30 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO Co. MD.	
10. CITY OR TOWN OF DEATH BALTO.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. Joseph's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAIL CLERK MONTG. WARD		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTO 13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE OAKLEE VILLAGE APT. 11 21228		
14. FATHER'S NAME FIRST WILLIAM K MIDDLE STITLEY LAST		15. MOTHER'S MAIDEN NAME FIRST LULA EDNA MIDDLE MAUGAINS LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-24-3186		17. INFORMANT ELIZABETH MITCHELL LANGEFORD RD 1519	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of the lung, anemia, sepsis. 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Poor perfusion both feet, atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Y. A. Tomke		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Y. A. Tomke		22e. ADDRESS 10 Warren Rd. Cockeysville, Md 21030			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 2/18/84	23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEM.		23d. LOCATION CITY OR TOWN COUNTY STATE SYKESSVILLE MD	23e. DATE REC'D. BY REGISTRAR FEB 17 1984
24. FUNERAL DIRECTOR NAME WEBER FUNERAL HOME		ADDRESS 5311 EDMONDSON AVE		25. REGISTRAR'S SIGNATURE John Davidson-Rendell	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the state health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.



*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Kathryn H. Cuomo				2a. DATE OF DEATH MONTH DAY YEAR 2 - 22 - 84			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 - 04 - 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8844 Satyr Hill Rd. 21234		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md.		13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1700 Aberdeen Rd. 21234	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick J. Eckert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Kathman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 220-46-5356		17. INFORMANT ADDRESS Mr. & Mrs. Frederick J. Cuomo 1535 E. 36th St. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>4/4/83</u> , 19 <u>83</u> , to <u>Feb 22</u> , 19 <u>84</u> , that (1) (we) lost saw the deceased alive on <u>2/10</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Sheldon H. Gottlieb</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SHELDON H. GOTTLIEB M.D.		22e. ADDRESS BALTIMORE CITY HOSPITALS 21224					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-25-84		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Joseph N. Zannino Jr. 263 S. Conkling St.				25a. DATE REC'D. BY REGISTRAR FEB 27 1984			
				25b. REGISTRAR'S SIGNATURE <i>Lia Davidson</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18, there is any injury, or other traumatic event, the medical examiner must perform an autopsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MARY MAGDALINE DAKIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEB 14, 1984</b>			2b. HOUR <b>5<sup>01</sup> PM</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 20 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>			10. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK, SECTOR, INDUSTRY, ETC.) <b>SALESPERSON</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>BALTIMORE</b>		13c. CITY OR TOWN <b>TOWSON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>DULANEY VALLEY ROAD 21204</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>PHILLIP HENRY TRAYSER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY KATHERINE BADDINGER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>217-16-1139</b>		17. INFORMANT ADDRESS <b>MARY DULEY 2301 ELLEN AVE BALT 21234</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY FAILURE</b> <b>5400</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GENERALIZED PERITONITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>LT COLON OBSTRUCTION - RUPTURED CECUM</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b> <b>1 MO.</b> <b>1 MO.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>											
19a. DATE OF OPERATION <b>1-17 &amp; 2-3-84</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cecal Perforation - Peritonitis</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1205 YORK RD LUTHERVILLE MD</b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>1-17-</b> , 19 <b>84</b> , to <b>2-14</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John J. Krejci MD</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-15-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN J. KREJCI</b>				22e. ADDRESS <b>1205 YORK RD LUTHERVILLE MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/17/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOST HOLY REDEEMER</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR <b>DIPPEL FUNERAL HOMES BALTIMORE MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 17 1984</b>					
25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at his/her residence.

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DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>FRANK Stanton DAUGHERTY</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>2 14 84</b>		2b. HOUR <b>10 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 16 36</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>47</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Finksburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4501 Louis Ville Rd 21048</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Melvin August Daugherty</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Doris Eileen Resau</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>219-32-9156</b>		17. INFORMANT ADDRESS <b>Mary Evans Daugherty, Finksburg</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>4:00</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>PREVIOUS MYOCARDIAL INFARCTION; DIABETES MELLITUS -</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>2-14-1984</b> to <b>2-14-1984</b> , that (I) (we) lost saw the deceased alive on <b>2-14-1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R. DeFestire</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>2-14-84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. DEFESTIRE</b>				22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-17-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Finksburg Carroll Md</b>					
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Sykesville</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Randall</b>					

MEDICAL CERTIFICATION



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03369

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George W. Davidson			2a. DATE OF DEATH MONTH DAY YEAR February 22, 1984			2b. HOUR M	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Ruxton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 29 Ruxview Court, Ruxton Village Apt.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retr. Exec.	
12b. KIND OF BUSINESS OR INDUSTRY Tin Products							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Ruxton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 29 Ruxview Court - 21204							
14. FATHER'S NAME FIRST MIDDLE LAST George Wood Davidson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Landauer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-01-5061A		17. INFORMANT ADDRESS Mrs. Doris Davidson 29 Ruxview Ct. Bal. Md. 21204			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4140  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Arteriosclerotic Heart Disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 19 78, to Feb 22, 19 84, that (1) (we) last saw the deceased alive on Feb 11, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert E. Stoner				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-23-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert E. Stoner				22e. ADDRESS 714 York Road			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 25, 1984		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore -- MD.	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home 6500 York Rd. Bal. Md. 21214				25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Rendall	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03370

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY V DAVILLA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-18-84</b>			2b. HOUR <b>12<sup>25</sup> PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 7, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Glyndon</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>E. D. Belt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Virgina Belt</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-12-5080</b>	
17. INFORMANT <b>Georgia Watts</b>		18. ADDRESS <b>212 Reisterstown Rd. Reisterstown, Md. 21136</b>		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-6-84</b> to <b>2-18-84</b> that (I) (we) last saw the deceased alive on <b>2-18-84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Soon Chul Hong</b>		22c. DATE SIGNED <b>2-18-84</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOON CHUL HONG</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremations</b>		23b. DATE <b>Feb. 21, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James H. Hightower</b>		24a. ADDRESS <b>Owings Mills, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 23 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1980 037

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03371	
1. DECEASED NAME (TYPE OR PRINT) <b>Lillian P. Davis</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2-28 1984</b>		2b. HOUR <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 5 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>2-28 1984</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5903 Bland Avenue Baltimore, Maryland 21215</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Levi Pearson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes</b>				16. ADDRESS <b>5953 Western Run Dr. Apt. C. 21215</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>220-20-8707</b>		17. INFORMANT <b>Barbara L. Davis</b>		17. ADDRESS <b>Dr. Apt. C. 21215</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Dennis F. Smyth MD</i>						TITLE (SPECIFY) <b>M.D. Assistant</b>			DATE SIGNED <b>2-29-84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Dennis F. Smyth, M.D.</b>						ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/3/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Nutter &amp; Sons Funeral Home Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			
2501 Gwynns Falls Pkwy. Baltimore, Md. 21216											

BP

March 1963

South Carolina

Supervisor  
2903 Main Avenue  
Baltimore, Maryland 21212

Baltimore

Maryland

Address

Level

2923 Western Road

820-10-8707

No.

Baltimore, Md. 21212

Baltimore, Maryland

2/2/1964

Walter & Sons Funeral Home Inc.

2901 Nevada Falls Drive, Baltimore, Md. 21212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 03372				
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>Freda Katherine Day</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>02 23 84</b>				2b. HOUR <b>11:25<sup>A</sup></b>
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 07 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Ct., Catonsville</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Import/Export Brokers</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>437 S. Bentalou Street, 21223</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Kirchner</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Augusta M. Leaman</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-09-0592</b>		17. INFORMANT ADDRESS <b>Catherine Franck 5943 Benton Hgts. Ave. 21206</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHD - Atrial Fib</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASVD - Valvular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-20-83</b> , 19____, to <b>2-23-84</b> , 19____, that (I) (we) last saw the deceased alive on <b>2-21-84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>George Angov</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-24-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Angov, M.D.</b>					22e. ADDRESS <b>3350 Wilkens Avenue, 21229</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>02-27-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hubbard Funeral Home, Inc. 4107 Wilkens Ave.</b>					25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE <b>FEB 27 1984</b> <b>John Davidson-Randall</b>				





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. \_\_\_\_\_

1. DECEASED NAME (TYPE OR PRINT) <b>(JOHN) GIOVANNI DEANGELIS</b>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH <b>2</b> DAY <b>11</b> YEAR <b>1984</b>		2b. HOUR <b>0400</b> AM
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>26</b> YEAR <b>1998</b>	6. AGE (IN YEARS (LAST BIRTHDAY)) <b>85</b> YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>DUNDALK BALTO</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>107 CENTRE AVE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BETH STEEL</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>DUNDALK</b>
14. FATHER'S NAME FIRST _____ MIDDLE _____ LAST _____		15. MOTHER'S MAIDEN NAME FIRST _____ MIDDLE _____ LAST _____		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-07-2897</b>		17. INFORMANT ADDRESS <b>HENRIETTA LUPSE 107 CENTRE AVE 21222</b>
18. CAUSE OF DEATH (Enter only one cause pending for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4148</b> IMMEDIATE CAUSE (a) <b>Chronic ischemic myocardial disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic generalized ischemic vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Carcinoma of stomach</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion				
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>		TITLE (SPECIFY) <b>Deputy</b>		DATE SIGNED <b>2/11/84</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>		ADDRESS <b>2112 Dundalk Ave., Balb., Md. 21222</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>2/14/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>CONNELLY FUNERAL HOME OF DUNDALK</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

UNCLASSIFIED

DECLASSIFIED

CONFIDENTIAL - NO FORN DISSEM

2/14/84

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes," it shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03374			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST <i>Richard F. Denny</i>				Feb. 26, 1984 M			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 2, 1929</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>55</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore County General Hosp.</i>		12a. USUAL OCCUPATION (WORKING LIFE) <i>Purchasing Agent</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>M.C.R.</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>xx</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>George F. Denny</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alma G. Green</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW 2 216 24 2265</i>		17. INFORMANT ADDRESS <i>family records</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Intermittent Cardiac Disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2500 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Double Myeloid</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) visit the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHARLES HATTON</i>				22e. ADDRESS <i>7600 OSLER DR TOWSON, MD 21204</i>		22f. DATE SIGNED <i>2/27/84</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>3/1/1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Howard County, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Evans Chapel of Memories 8800 Harford Road</i>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>MAR 2 1984 John Davidson-Randall</i>			



Alfred L. Williams, Jr.  
Bapt. Minister

Charles H. Hatten

12/2/54  
George D. Johnson, Jr.

Mr. S. B. Johnson, Jr.  
12/2/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Elizabeth L. Dickel</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>February 06, 1984</i>		2b. HOUR <i>4:30 P.M.</i>	
3. SEX <i>Female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Nov 15, 1902</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>81</i> YRS.		# UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.			
10. CITY OR TOWN OF DEATH <i>Arbutus</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4926 Gateway Terrace</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Arbutus</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>4926 Gateway Terrace 21227</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Steven Letrichet</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS <i>Mr. George L. Dickel 4926 Gateway Terrace 21227</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal Failure</i> <i>2028</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pelvic Lymphoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) ----- DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>1 yr</i>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) -----						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>1/26</i> 19 <i>83</i> to <i>2/7</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>1/26</i> 19 <i>84</i> , and that in <input checked="" type="radio"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did not view the body after death.						
22b. SIGNATURE <i>Dr. C. Waterfield</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Feb 07, 1984</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Waterfield</i>		22e. ADDRESS <i>St. Agnes Hospital Wilkens &amp; Caton Aves</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>2/9/84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Ambrose Funeral Home</i>		ADDRESS <i>1328 Sulphur Spring Rd.</i>		25. DATE REC'D. BY REGISTRAR <i>FEB 7 1984</i>		
		26. REGISTRAR'S SIGNATURE <i>John J. Conner</i>				

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03376

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR A. M.	
ANTHONY F. DIETER						2 19 84				11:45	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		MONTH DAY YEAR 7 7 24		59		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
White Marsh		5011 White Marsh Rd. 21237						machinist		Metal Craft	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		BALTIMORE				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5011 White Marsh Rd. 21237			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Henry J. Dieter				FIRST MIDDLE LAST Johannah White							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
yes				WW 11		218-26-8731 Gordon F. Dieter Balto., Md. 21237					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b>											
4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b>										2 months	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b>										2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:											
<b>Anemia. Peptic Ulcer Disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> attended the deceased from <u>February</u> , 19 <u>59</u> , to <u>February</u> , 19 <u>84</u> , that (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> lost saw the deceased alive on <u>Feb. 4</u> , 19 <u>84</u> , and that in (my) <input checked="" type="checkbox"/> (our) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<i>Theodore Evans</i>				20 ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				2-20-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Theodore Evans, M.D.				9660 Belair Rd. 256-3950							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			2-23-84		St. Joseph's Cem.			Baltimore, Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE RECD. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Lassahn Funeral Home				4701 Belair Rd. Balto., Md. 21236				FEB 23 1984 Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Item 16b, film#G589 -

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03371

1- FOR STATE REGISTRAR  
3-7-84jlb

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>William John Dombroski -DOVER</i>			2a. DATE OF DEATH MONTH DAY YEAR February 27, 1984			2b. HOUR 6:27p M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 22 21		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) One Sampler		12b. KIND OF BUSINESS OR INDUSTRY Booth Garry, Blair	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Dombroski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Grauling			13e. STREET ADDRESS / ZIP CODE 7642 Dunman Way 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2 214-16-9955		17. INFORMANT ADDRESS Theresa A. Dombroski 7642 Dunman Way 21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Heart failure DUE TO, OR AS A CONSEQUENCE OF } (c) Coronary artery disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from February 27, 1984, to February 27, 1984, that (we) lost saw the deceased alive on February 27, 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/27/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose ARDAIZ, MD			22e. ADDRESS 7838 EASTERN AVE. BALTIMORE, Md 21224						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-3-84		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Eastwood, Balto. Co., Md.		
24. FUNERAL HOME <i>Charles S. Zeiler &amp; Son Inc.</i>			25. DATE REC'D. BY REGISTRAR MAR 2 1984			REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MARY L. DOOLEY</b>						2a. DATE OF DEATH		MONTH <b>2</b> DAY <b>3</b> YEAR <b>84</b>		2b. HOUR <b>845</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>20</b> YEAR <b>96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Perring Parkway Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b></b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3102 Abell Avenue 21218</b>	
14. FATHER'S NAME FIRST <b>Ward</b> MIDDLE <b></b> LAST <b>Leftwich</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Sally</b> MIDDLE <b></b> LAST <b>Mitchell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-34-6163</b>		17. INFORMANT ADDRESS <b>Guy J. LaBanz 5215 Eugene Ave. 21206</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>Acute CVA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b>										years <b></b>	
(c) <b></b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Dehydration</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Gracia V. Patricia</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gracia V. Patricia</b>				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb 6 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b> ADDRESS <b>Baltimore, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 7 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carick</b>			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03379

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>AGNES ENA DOTTERWEICH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEB. 12 1984</b>		2b. HOUR <b>3 15 PM</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1/14/00</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>ESSEX</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1556 GALENA RD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POLICE</b>	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>			13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>ESSEX</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALFRED 1BBOIT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY HAMMIE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213 18 9505</b>	17. INFORMANT ADDRESS <b>MARY GRISINGER ABOVE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>2 YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 19 55</b> to <b>FEB 12 19 84</b> , that (I) (we) lost saw the deceased alive on <b>FEB. 7 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph Miceli MD</b>				22c. DATE SIGNED <b>2/14/84</b>	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH MICELI MD</b>				22b. ADDRESS <b>108 S. TAYLOR AVE ESSEX, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/15/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD</b>
24. FUNERAL DIRECTOR NAME <b>J.E. CONNELLY</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1984</b>	
ADDRESS <b>300 MACE</b>				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the attending physician must be notified at once.

Items 23a, 23c, 23d, 23e, 23f, 23g, 23h, 23i, 23j, 23k, 23l, 23m, 23n, 23o, 23p, 23q, 23r, 23s, 23t, 23u, 23v, 23w, 23x, 23y, 23z, 23aa, 23ab, 23ac, 23ad, 23ae, 23af, 23ag, 23ah, 23ai, 23aj, 23ak, 23al, 23am, 23an, 23ao, 23ap, 23aq, 23ar, 23as, 23at, 23au, 23av, 23aw, 23ax, 23ay, 23az, 23ba, 23bb, 23bc, 23bd, 23be, 23bf, 23bg, 23bh, 23bi, 23bj, 23bk, 23bl, 23bm, 23bn, 23bo, 23bp, 23bq, 23br, 23bs, 23bt, 23bu, 23bv, 23bw, 23bx, 23by, 23bz, 23ca, 23cb, 23cc, 23cd, 23ce, 23cf, 23cg, 23ch, 23ci, 23cj, 23ck, 23cl, 23cm, 23cn, 23co, 23cp, 23cq, 23cr, 23cs, 23ct, 23cu, 23cv, 23cw, 23cx, 23cy, 23cz, 23da, 23db, 23dc, 23dd, 23de, 23df, 23dg, 23dh, 23di, 23dj, 23dk, 23dl, 23dm, 23dn, 23do, 23dp, 23dq, 23dr, 23ds, 23dt, 23du, 23dv, 23dw, 23dx, 23dy, 23dz, 23ea, 23eb, 23ec, 23ed, 23ee, 23ef, 23eg, 23eh, 23ei, 23ej, 23ek, 23el, 23em, 23en, 23eo, 23ep, 23eq, 23er, 23es, 23et, 23eu, 23ev, 23ew, 23ex, 23ey, 23ez, 23fa, 23fb, 23fc, 23fd, 23fe, 23ff, 23fg, 23fh, 23fi, 23fj, 23fk, 23fl, 23fm, 23fn, 23fo, 23fp, 23fq, 23fr, 23fs, 23ft, 23fu, 23fv, 23fw, 23fx, 23fy, 23fz, 23ga, 23gb, 23gc, 23gd, 23ge, 23gf, 23gg, 23gh, 23gi, 23gj, 23gk, 23gl, 23gm, 23gn, 23go, 23gp, 23gq, 23gr, 23gs, 23gt, 23gu, 23gv, 23gw, 23gx, 23gy, 23gz, 23ha, 23hb, 23hc, 23hd, 23he, 23hf, 23hg, 23hh, 23hi, 23hj, 23hk, 23hl, 23hm, 23hn, 23ho, 23hp, 23hq, 23hr, 23hs, 23ht, 23hu, 23hv, 23hw, 23hx, 23hy, 23hz, 23ia, 23ib, 23ic, 23id, 23ie, 23if, 23ig, 23ih, 23ii, 23ij, 23ik, 23il, 23im, 23in, 23io, 23ip, 23iq, 23ir, 23is, 23it, 23iu, 23iv, 23iw, 23ix, 23iy, 23iz, 23ja, 23jb, 23jc, 23jd, 23je, 23jf, 23jg, 23jh, 23ji, 23jj, 23jk, 23jl, 23jm, 23jn, 23jo, 23jp, 23jq, 23jr, 23js, 23jt, 23ju, 23jv, 23jw, 23jx, 23jy, 23jz, 23ka, 23kb, 23kc, 23kd, 23ke, 23kf, 23kg, 23kh, 23ki, 23kj, 23kk, 23kl, 23km, 23kn, 23ko, 23kp, 23kq, 23kr, 23ks, 23kt, 23ku, 23kv, 23kw, 23kx, 23ky, 23kz, 23la, 23lb, 23lc, 23ld, 23le, 23lf, 23lg, 23lh, 23li, 23lj, 23lk, 23ll, 23lm, 23ln, 23lo, 23lp, 23lq, 23lr, 23ls, 23lt, 23lu, 23lv, 23lw, 23lx, 23ly, 23lz, 23ma, 23mb, 23mc, 23md, 23me, 23mf, 23mg, 23mh, 23mi, 23mj, 23mk, 23ml, 23mn, 23mo, 23mp, 23mq, 23mr, 23ms, 23mt, 23mu, 23mv, 23mw, 23mx, 23my, 23mz, 23na, 23nb, 23nc, 23nd, 23ne, 23nf, 23ng, 23nh, 23ni, 23nj, 23nk, 23nl, 23nm, 23nn, 23no, 23np, 23nq, 23nr, 23ns, 23nt, 23nu, 23nv, 23nw, 23nx, 23ny, 23nz, 23oa, 23ob, 23oc, 23od, 23oe, 23of, 23og, 23oh, 23oi, 23oj, 23ok, 23ol, 23om, 23on, 23oo, 23op, 23oq, 23or, 23os, 23ot, 23ou, 23ov, 23ow, 23ox, 23oy, 23oz, 23pa, 23pb, 23pc, 23pd, 23pe, 23pf, 23pg, 23ph, 23pi, 23pj, 23pk, 23pl, 23pm, 23pn, 23po, 23pp, 23pq, 23pr, 23ps, 23pt, 23pu, 23pv, 23pw, 23px, 23py, 23pz, 23qa, 23qb, 23qc, 23qd, 23qe, 23qf, 23qg, 23qh, 23qi, 23qj, 23qk, 23ql, 23qm, 23qn, 23qo, 23qp, 23qq, 23qr, 23qs, 23qt, 23qu, 23qv, 23qw, 23qx, 23qy, 23qz, 23ra, 23rb, 23rc, 23rd, 23re, 23rf, 23rg, 23rh, 23ri, 23rj, 23rk, 23rl, 23rm, 23rn, 23ro, 23rp, 23rq, 23rr, 23rs, 23rt, 23ru, 23rv, 23rw, 23rx, 23ry, 23rz, 23sa, 23sb, 23sc, 23sd, 23se, 23sf, 23sg, 23sh, 23si, 23sj, 23sk, 23sl, 23sm, 23sn, 23so, 23sp, 23sq, 23sr, 23ss, 23st, 23su, 23sv, 23sw, 23sx, 23sy, 23sz, 23ta, 23tb, 23tc, 23td, 23te, 23tf, 23tg, 23th, 23ti, 23tj, 23tk, 23tl, 23tm, 23tn, 23to, 23tp, 23tq, 23tr, 23ts, 23tt, 23tu, 23tv, 23tw, 23tx, 23ty, 23tz, 23ua, 23ub, 23uc, 23ud, 23ue, 23uf, 23ug, 23uh, 23ui, 23uj, 23uk, 23ul, 23um, 23un, 23uo, 23up, 23uq, 23ur, 23us, 23ut, 23uu, 23uv, 23uw, 23ux, 23uy, 23uz, 23va, 23vb, 23vc, 23vd, 23ve, 23vf, 23vg, 23vh, 23vi, 23vj, 23vk, 23vl, 23vm, 23vn, 23vo, 23vp, 23vq, 23vr, 23vs, 23vt, 23vu, 23vv, 23vw, 23vx, 23vy, 23vz, 23wa, 23wb, 23wc, 23wd, 23we, 23wf, 23wg, 23wh, 23wi, 23wj, 23wk, 23wl, 23wm, 23wn, 23wo, 23wp, 23wq, 23wr, 23ws, 23wt, 23wu, 23wv, 23ww, 23wx, 23wy, 23wz, 23xa, 23xb, 23xc, 23xd, 23xe, 23xf, 23xg, 23xh, 23xi, 23xj, 23xk, 23xl, 23xm, 23xn, 23xo, 23xp, 23xq, 23xr, 23xs, 23xt, 23xu, 23xv, 23xw, 23xx, 23xy, 23xz, 23ya, 23yb, 23yc, 23yd, 23ye, 23yf, 23yg, 23yh, 23yi, 23yj, 23yk, 23yl, 23ym, 23yn, 23yo, 23yp, 23yq, 23yr, 23ys, 23yt, 23yu, 23yv, 23yw, 23yx, 23yy, 23yz, 23za, 23zb, 23zc, 23zd, 23ze, 23zf, 23zg, 23zh, 23zi, 23zj, 23zk, 23zl, 23zm, 23zn, 23zo, 23zp, 23zq, 23zr, 23zs, 23zt, 23zu, 23zv, 23zw, 23zx, 23zy, 23zz, 23aa, 23ab, 23ac, 23ad, 23ae, 23af, 23ag, 23ah, 23ai, 23aj, 23ak, 23al, 23am, 23an, 23ao, 23ap, 23aq, 23ar, 23as, 23at, 23au, 23av, 23aw, 23ax, 23ay, 23az, 23ba, 23bb, 23bc, 23bd, 23be, 23bf, 23bg, 23bh, 23bi, 23bj, 23bk, 23bl, 23bm, 23bn, 23bo, 23bp, 23bq, 23br, 23bs, 23bt, 23bu, 23bv, 23bw, 23bx, 23by, 23bz, 23ca, 23cb, 23cc, 23cd, 23ce, 23cf, 23cg, 23ch, 23ci, 23cj, 23ck, 23cl, 23cm, 23cn, 23co, 23cp, 23cq, 23cr, 23cs, 23ct, 23cu, 23cv, 23cw, 23cx, 23cy, 23cz, 23da, 23db, 23dc, 23dd, 23de, 23df, 23dg, 23dh, 23di, 23dj, 23dk, 23dl, 23dm, 23dn, 23do, 23dp, 23dq, 23dr, 23ds, 23dt, 23du, 23dv, 23dw, 23dx, 23dy, 23dz, 23ea, 23eb, 23ec, 23ed, 23ee, 23ef, 23eg, 23eh, 23ei, 23ej, 23ek, 23el, 23em, 23en, 23eo, 23ep, 23eq, 23er, 23es, 23et, 23eu, 23ev, 23ew, 23ex, 23ey, 23ez, 23fa, 23fb, 23fc, 23fd, 23fe, 23ff, 23fg, 23fh, 23fi, 23fj, 23fk, 23fl, 23fm, 23fn, 23fo, 23fp, 23fq, 23fr, 23fs, 23ft, 23fu, 23fv, 23fw, 23fx, 23fy, 23fz, 23ga, 23gb, 23gc, 23gd, 23ge, 23gf, 23gg, 23gh, 23gi, 23gj, 23gk, 23gl, 23gm, 23gn, 23go, 23gp, 23gq, 23gr, 23gs, 23gt, 23gu, 23gv, 23gw, 23gx, 23gy, 23gz, 23ha, 23hb, 23hc, 23hd, 23he, 23hf, 23hg, 23hh, 23hi, 23hj, 23hk, 23hl, 23hm, 23hn, 23ho, 23hp, 23hq, 23hr, 23hs, 23ht, 23hu, 23hv, 23hw, 23hx, 23hy, 23hz, 23ia, 23ib, 23ic, 23id, 23ie, 23if, 23ig, 23ih, 23ii, 23ij, 23ik, 23il, 23im, 23in, 23io, 23ip, 23iq, 23ir, 23is, 23it, 23iu, 23iv, 23iw, 23ix, 23iy, 23iz, 23ja, 23jb, 23jc, 23jd, 23je, 23jf, 23jg, 23jh, 23ji, 23jj, 23jk, 23jl, 23jm, 23jn, 23jo, 23jp, 23jq, 23jr, 23js, 23jt, 23ju, 23jv, 23jw, 23jx, 23jy, 23jz, 23ka, 23kb, 23kc, 23kd, 23ke, 23kf, 23kg, 23kh, 23ki, 23kj, 23kk, 23kl, 23km, 23kn, 23ko, 23kp, 23kq, 23kr, 23ks, 23kt, 23ku, 23kv, 23kw, 23kx, 23ky, 23kz, 23la, 23lb, 23lc, 23ld, 23le, 23lf, 23lg, 23lh, 23li, 23lj, 23lk, 23ll, 23lm, 23ln, 23lo, 23lp, 23lq, 23lr, 23ls, 23lt, 23lu, 23lv, 23lw, 23lx, 23ly, 23lz, 23ma, 23mb, 23mc, 23md, 23me, 23mf, 23mg, 23mh, 23mi, 23mj, 23mk, 23ml, 23mn, 23mo, 23mp, 23mq, 23mr, 23ms, 23mt, 23mu, 23mv, 23mw, 23mx, 23my, 23mz, 23na, 23nb, 23nc, 23nd, 23ne, 23nf, 23ng, 23nh, 23ni, 23nj, 23nk, 23nl, 23nm, 23nn, 23no, 23np, 23nq, 23nr, 23ns, 23nt, 23nu, 23nv, 23nw, 23nx, 23ny, 23nz, 23oa, 23ob, 23oc, 23od, 23oe, 23of, 23og, 23oh, 23oi, 23oj, 23ok, 23ol, 23om, 23on, 23oo, 23op, 23oq, 23or, 23os, 23ot, 23ou, 23ov, 23ow, 23ox, 23oy, 23oz, 23pa, 23pb, 23pc, 23pd, 23pe, 23pf, 23pg, 23ph, 23pi, 23pj, 23pk, 23pl, 23pm, 23pn, 23po, 23pp, 23pq, 23pr, 23ps, 23pt, 23pu, 23pv, 23pw, 23px, 23py, 23pz, 23qa, 23qb, 23qc, 23qd, 23qe, 23qf, 23qg, 23qh, 23qi, 23qj, 23qk, 23ql, 23qm, 23qn, 23qo, 23qp, 23qq, 23qr, 23qs, 23qt, 23qu, 23qv, 23qw, 23qx, 23qy, 23qz, 23ra, 23rb, 23rc, 23rd, 23re, 23rf, 23rg, 23rh, 23ri, 23rj, 23rk, 23rl, 23rm, 23rn, 23ro, 23rp, 23rq, 23rr, 23rs, 23rt, 23ru, 23rv, 23rw, 23rx, 23ry, 23rz, 23sa, 23sb, 23sc, 23sd, 23se, 23sf, 23sg, 23sh, 23si, 23sj, 23sk, 23sl, 23sm, 23sn, 23so, 23sp, 23sq, 23sr, 23ss, 23st, 23su, 23sv, 23sw, 23sx, 23sy, 23sz, 23ta, 23tb, 23tc, 23td, 23te, 23tf, 23tg, 23th, 23ti, 23tj, 23tk, 23tl, 23tm, 23tn, 23to, 23tp, 23tq, 23tr, 23ts, 23tt, 23tu, 23tv, 23tw, 23tx, 23ty, 23tz, 23ua, 23ub, 23uc, 23ud, 23ue, 23uf, 23ug, 23uh, 23ui, 23uj, 23uk, 23ul, 23um, 23un, 23uo, 23up, 23uq, 23ur, 23us, 23ut, 23uu, 23uv, 23uw, 23ux, 23uy, 23uz, 23va, 23vb, 23vc, 23vd, 23ve, 23vf, 23vg, 23vh, 23vi, 23vj, 23vk, 23vl, 23vm, 23vn, 23vo, 23vp, 23vq, 23vr, 23vs, 23vt, 23vu, 23vv, 23vw, 23vx, 23vy, 23vz, 23wa, 23wb, 23wc, 23wd, 23we, 23wf, 23wg, 23wh, 23wi, 23wj, 23wk, 23wl, 23wm, 23wn, 23wo, 23wp, 23wq, 23wr, 23ws, 23wt, 23wu, 23wv, 23ww, 23wx, 23wy, 23wz, 23xa, 23xb, 23xc, 23xd, 23xe, 23xf, 23xg, 23xh, 23xi, 23xj, 23xk, 23xl, 23xm, 23xn, 23xo, 23xp, 23xq, 23xr, 23xs, 23xt, 23xu, 23xv, 23xw, 23xx, 23xy, 23xz, 23ya, 23yb, 23yc, 23yd, 23ye, 23yf, 23yg, 23yh, 23yi, 23yj, 23yk, 23yl, 23ym, 23yn, 23yo, 23yp, 23yq, 23yr, 23ys, 23yt, 23yu, 23yv, 23yw, 23yx, 23yy, 23yz, 23za, 23zb, 23zc, 23zd, 23ze, 23zf, 23zg, 23zh, 23zi, 23zj, 23zk, 23zl, 23zm, 23zn, 23zo, 23zp, 23zq, 23zr, 23zs, 23zt, 23zu, 23zv, 23zw, 23zx, 23zy, 23zz										23c, 23d, 23e, 23f, 23g, 23h, 23i, 23j, 23k, 23l, 23m, 23n, 23o, 23p, 23q, 23r, 23s, 23t, 23u, 23v, 23w, 23x, 23y, 23z, 23aa, 23ab, 23ac, 23ad, 23ae, 23af, 23ag, 23ah, 23ai, 23aj, 23ak, 23al, 23am, 23an, 23ao, 23ap, 23aq, 23ar, 23as, 23at, 23au, 23av, 23aw, 23ax, 23ay, 23az, 23ba, 23bb, 23bc, 23bd, 23be, 23bf, 23bg, 23bh, 23bi, 23bj, 23bk, 23bl, 23bm, 23bn, 23bo, 23bp, 23bq, 23br, 23bs, 23bt, 23bu, 23bv, 23bw, 23bx, 23by, 23bz, 23ca, 23cb, 23cc, 23cd, 23ce, 23cf, 23cg, 23ch, 23ci, 23cj, 23ck, 23cl, 23cm, 23cn, 23co, 23cp, 23cq, 23cr, 23cs, 23ct, 23cu, 23cv, 23cw, 23cx, 23cy, 23cz, 23da, 23db, 23dc, 23dd, 23de, 23df, 23dg, 23dh, 23di, 23dj, 23dk, 23dl, 23dm, 23dn, 23do, 23dp, 23dq, 23dr, 23ds, 23dt, 23du, 23dv, 23dw, 23dx, 23dy, 23dz, 23ea, 23eb, 23ec, 23ed, 23ee, 23ef, 23eg, 23eh, 23ei, 23ej, 23ek, 23el, 23em, 23en, 23eo, 23ep, 23eq, 23er, 23es, 23et, 23eu, 23ev, 23ew, 23ex, 23ey, 23ez, 23fa, 23fb, 23fc, 23fd, 23fe, 23ff, 23fg, 23fh, 23fi, 23fj, 23fk, 23fl, 23fm, 23fn, 23fo, 23fp, 23fq, 23fr, 23fs, 23ft, 23fu, 23fv, 23fw, 23fx, 23fy, 23fz, 23ga, 23gb, 23gc, 23gd, 23ge, 23gf, 23gg, 23gh, 23gi, 23gj, 23gk, 23gl, 23gm, 23gn, 23go, 23gp, 23gq, 23gr, 23gs, 23gt, 23gu, 23gv, 23gw, 23gx, 23gy, 23gz, 23ha, 23hb, 23hc, 23hd, 23he, 23hf, 23hg, 23hh, 23hi, 23hj, 23hk, 23hl, 23hm, 23hn, 23ho, 23hp, 23hq, 23hr, 23hs, 23ht, 23hu, 23hv, 23hw, 23hx, 23hy, 23hz, 23ia, 23ib, 23ic, 23id, 23ie, 23if, 23ig, 23ih, 23ii, 23ij, 23ik, 23il, 23im, 23in, 23io, 23ip, 23iq, 23ir, 23is, 23it, 23iu, 23iv, 23iw, 23ix, 23iy, 23iz, 23ja, 23jb, 23jc, 23jd, 23je, 23jf, 23jg, 23jh, 23ji, 23jj, 23jk, 23jl, 23jm, 23jn, 23jo, 23jp, 23jq, 23jr, 23js, 23jt, 23ju, 23jv, 23jw, 23jx, 23jy, 23jz, 23ka, 23kb, 23kc, 23kd, 23ke, 23kf, 23kg, 23kh, 23ki, 23kj, 23kk, 23kl, 23km, 23kn, 23ko, 23kp, 23kq, 23kr, 23ks, 23kt, 23ku, 23kv, 23kw, 23kx, 23ky, 23kz, 23la, 23lb, 23lc, 23ld, 23le, 23lf, 23lg, 23lh, 23li, 23lj, 23lk, 23ll, 23lm, 23ln, 23lo, 23lp, 23lq, 23lr, 23ls, 23lt, 23lu, 23lv, 23lw, 23lx, 23ly, 23lz, 23ma, 23mb, 23mc, 23md, 23me, 23mf, 23mg, 23mh, 23mi, 23mj, 23mk, 23ml, 23mn, 23mo, 23mp, 23mq, 23mr, 23ms, 23mt, 23mu, 23mv, 23mw, 23mx, 23my, 23mz, 23na, 23nb, 23nc, 23nd, 23ne, 23nf, 23ng, 23nh, 23ni, 23nj, 23nk, 23nl, 23nm, 23nn, 23no, 23np, 23nq, 23nr, 23ns, 23nt, 23nu, 23nv, 23nw, 23nx, 23ny, 23nz, 23oa, 23ob, 23oc, 23od, 23oe, 23of, 23og, 23oh, 23oi, 23oj, 23ok, 23ol, 23om, 23on, 23oo, 23op, 23oq, 23or, 23os, 23ot, 23ou, 23ov, 23ow, 23ox, 23oy, 23oz, 23pa, 23pb, 23pc, 23pd, 23pe, 23pf, 23pg, 23ph, 23pi, 23pj, 23pk, 23pl, 23pm, 23pn, 23po, 23pp, 23pq, 23pr, 23ps, 23pt, 23pu, 23pv, 23pw, 23px, 23py, 23pz, 23qa, 23qb, 23qc, 23qd, 23qe, 23qf, 23qg, 23qh, 23qi, 23qj, 23qk, 23ql, 23qm, 23qn, 23qo, 23qp, 23qq, 23qr, 23qs, 23qt, 23qu, 23qv, 23qw, 23qx, 23qy, 23qz, 23ra, 23rb, 23rc, 23rd, 23re, 23rf, 23rg, 23rh, 23ri, 23rj, 23rk, 23rl, 23rm, 23rn, 23ro, 23rp, 23rq, 23rr, 23rs, 23rt, 23ru, 23rv, 23rw, 23rx, 23ry, 23rz, 23sa, 23sb, 23sc, 23sd, 23se, 23sf, 23sg, 23sh, 23si, 23sj, 23sk, 23sl, 23sm, 23sn, 23so, 23sp, 23sq, 23sr, 23ss, 23st, 23su, 23sv, 23sw, 23sx, 23sy, 23sz, 23ta, 23tb, 23tc, 23td, 23te, 23tf, 23tg, 23th, 23ti, 23tj, 23tk, 23tl, 23tm, 23tn, 23to, 23tp, 23tq, 23tr, 23ts, 23tt, 23tu, 23tv, 23tw, 23tx, 23ty, 23tz, 23ua, 23ub, 23uc, 23ud, 23ue, 23uf, 23ug, 23uh, 23ui, 23uj, 23uk, 23ul, 23um, 23un, 23uo, 23up, 23uq, 23ur, 23us, 23ut, 23uu, 23uv, 23uw, 23ux, 23uy, 23uz, 23va, 23vb, 23vc, 23vd, 23ve, 23vf, 23vg, 23vh, 23vi, 23vj, 23vk, 23vl, 23vm, 23vn, 23vo, 23vp, 23vq, 23vr, 23vs, 23vt, 23vu, 23vv, 23vw, 23vx, 23vy, 23vz, 23wa, 23wb, 23wc, 23wd, 23we, 23wf, 23wg, 23wh, 23wi, 23wj, 23wk, 23wl, 23wm, 23wn, 23wo, 23wp, 23wq, 23wr, 23ws, 23wt, 23wu, 23wv, 23ww, 23wx, 23wy, 23wz, 23xa, 23xb, 23xc, 23xd, 23xe, 23xf, 23xg, 23xh, 23xi, 23xj, 23xk, 23xl, 23xm, 23xn, 23xo, 23xp, 23xq, 23xr, 23xs, 23xt, 23xu, 23xv, 23xw, 23xx, 23xy, 23xz, 23ya, 23yb, 23yc, 23yd, 23ye, 23yf, 23yg, 23yh, 23yi, 23yj, 23yk, 23yl, 23ym, 23yn, 23yo, 23yp, 23yq, 23yr, 23ys, 23yt, 23yu, 23yv, 23yw, 23yx, 23yy, 23yz, 23za, 23zb, 23zc, 23zd, 23ze, 23zf, 23zg, 23zh, 23zi, 23zj, 23zk, 23zl, 23zm, 23zn, 23zo, 23zp, 23zq, 23zr, 23zs, 23zt, 23zu, 23zv, 23zw, 23zx, 23zy, 23zz																																							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FRANK S DRAPER</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>2/25/84</b>										2b. HOUR <b>3:01 PM</b>																													
3. SEX <b>MALE</b>										4. RACE <b>WHITE</b>										5. DATE OF BIRTH MONTH DAY YEAR <b>8 26 1916</b>										6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>67</b>										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>																			
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSP.</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELECTRICIAN</b>										12b. KIND OF BUSINESS OR INDUSTRY <b>EMERSON ELEC.</b>																			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>										13b. COUNTY <b>BALTIMORE</b>										13c. CITY OR TOWN <b>BALTIMORE</b>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS / ZIP CODE <b>9615 HARDING AVE 21234</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>PAUL S. DRAPER</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MYRTLE V. KIRK</b>																																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>										16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW2</b>										17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a. ACCIDENT																																																	



RECEIVED  
JAN 10 1964  
U.S. AIR FORCE



*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a series of lines of text, possibly a letter or a report, covering the majority of the page.]*

WAS 3 04



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03381

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ERNEST L. DRISGILL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 10, 1984</b>			2b. HOUR <b>1:25<sup>P</sup> M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 29, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		7. UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>21234</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley Nursing and Convalescent Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>--</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2 S. Patomac Street 21224</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Drisgill</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Belle Moore</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW1</b>		17. INFORMANT ADDRESS <b>James A. Gede 24 W. Penna. Av. 21204</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Bacteremia**

DUE TO, OR AS A CONSEQUENCE OF

1369  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b)

**Deep soft tissue infection**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

**Senescence, depression and will to die**

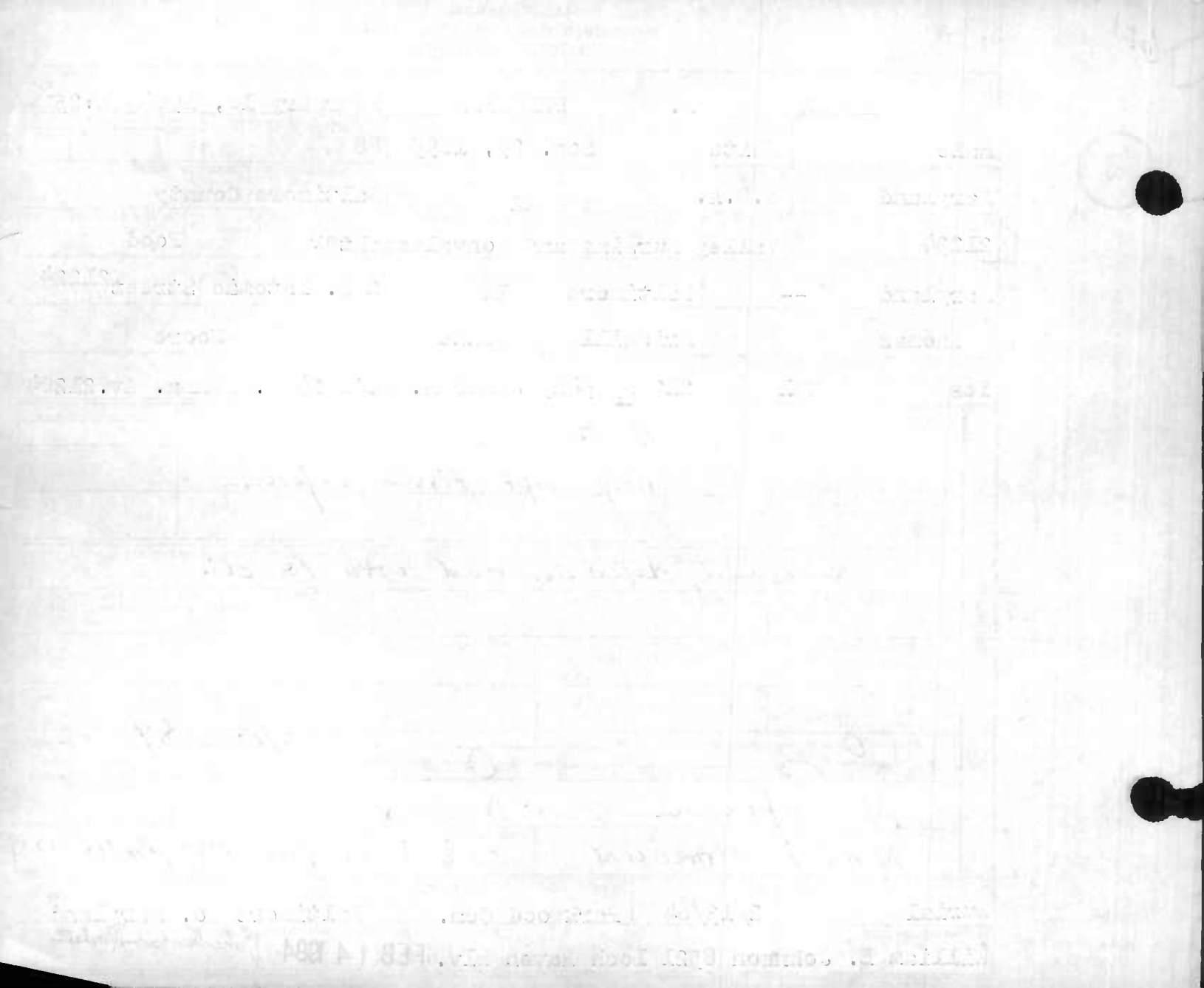
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <b>N. Haroun</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NAJJI HAROUN</b>				22e. ADDRESS <b>108 S. Taylor Ave, Balto 21221</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/13/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>William E. Johnson 8521 Loch Raven Blv.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>			
				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner will be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 3 8 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK H DROUGHT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2/14/84</b>			2b. HOUR <b>3:05P</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N CHARLES ST GBMC</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief Maintenance Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4205 Eastview Rd 21218</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph P Drought</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Erhardt</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 1 215-03-0904</b>		17. INFORMANT ADDRESS <b>Mrs Josefyn Drought Same As 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4860 RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RESPIRATORY ACIDOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>PNEUMONIA</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> , 19 <b>84</b> , to <b>2/14</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Moh. C. Davis</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-14-84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR M DAVIS</b>					22e. ADDRESS <b>GBMC</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/17/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1984</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

3:02P

2/14/68

PROJECT

FAK X



BALTIMORE COUNTY

771 - 67425 27 4-10

RESPIRATORY ACIDOSIS  
PNEUMONIA  
BEST WITH A WASH

11 11

11 11

11 11

11 11

11 11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE R. DUKES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 26 84</b>			2b. HOUR <b>1:45P M</b>				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 21 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1238 Potomac Street 21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thad Dukes</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Claudia Bryant</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>245-16-5638</b>		17. INFORMANT <b>Vonzella Morgan</b>			ADDRESS <b>1238 Potomac St.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Widely metastatic carcinoma</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 30</b> , 19 <b>84</b> , to <b>Feb. 26</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Feb. 26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robert A. Palermo, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-27-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert A. Palermo, M.D.</b>						22e. ADDRESS <b>6701 N. Charles St. Towson, MD 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrison Forest VA Owings Mills, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Wm C March F/H Inc. 1101 E North Avenue</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 29 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

1966

BOARD



2066

CHIEF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director for page 4, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHM - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DELMAS JOSEPH DUNN			February 19 1984			9:15A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR FEB. 8, 1907		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 77 YRS		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 602 HOLLEN RD. 21212	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH SAMUEL DUNN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH STEINICK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-10-6038		17. INFORMANT ADDRESS EDNA H. DUNN 602 HOLLEN RD. 21212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 5609 } DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Arrhythmia (c) Intestinal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Arteriosclerotic Cardiovascular Disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1984, to Feb. 19, 1984, that (I) (we) last saw the deceased alive on Feb. 19, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE John E. Adams, M.D.								22c. DATE SIGNED Feb. 19, 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Adams, M.D.				22e. ADDRESS 6701 N. Charles Street, Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 22, 1984		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PIKESVILLE BALTO. MD.			
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME				24. FUNERAL DIRECTOR ADDRESS 6500 YORK RD. 21212		25a. DATE REC'D BY REGISTRAR FEB 23 1984			
				25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall					

BP



8006-01-212

1887 3 2 1884

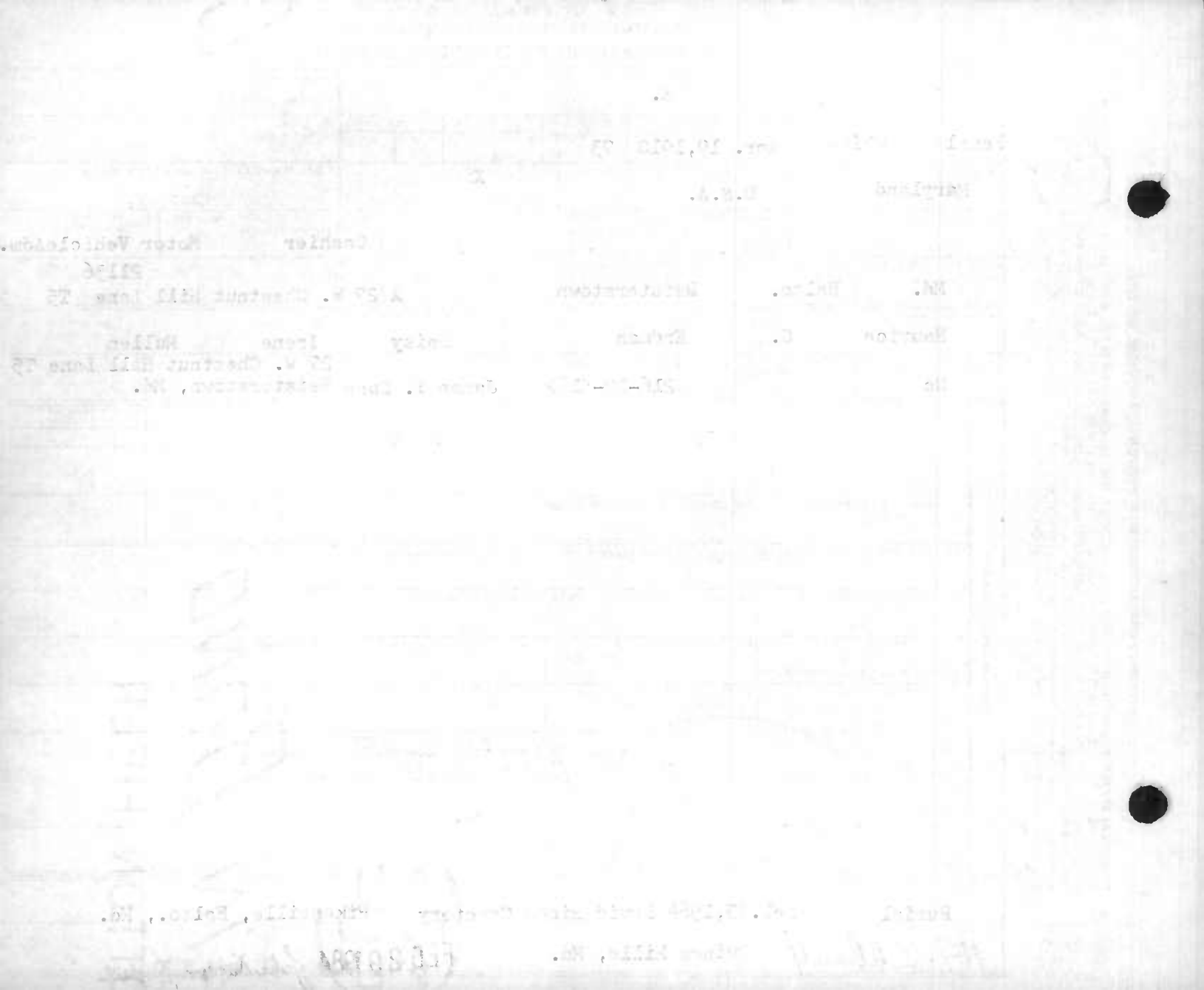


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BP.

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																													
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE KNOWN OF DEATH										2b. DATE OF DEATH										2c. DATE OF DEATH																													
FIRST MIDDLE LAST										MONTH DAY YEAR										MONTH DAY YEAR										MONTH DAY YEAR																													
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										7. DATE OF BIRTH										8. DATE OF BIRTH									
Female										White										Apr. 19, 1910										73 YRS.										Apr. 19, 1910										Apr. 19, 1910									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH										10. BALTIMORE CITY OR COUNTY OF DEATH																			
Maryland										U.S.A.										WIDOWED										Baltimore County,										Baltimore County,																			
11. CITY OR TOWN OF DEATH										12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										13. USUAL OCCUPATION (TYPE OF WORK)										14. KIND OF BUSINESS OR INDUSTRY										15. KIND OF BUSINESS OR INDUSTRY																			
Randallstown										Baltimore County General Hospital										Cashier										Motor Vehicle Adm.										Motor Vehicle Adm.																			
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										17. CITY OR TOWN										18. STREET ADDRESS										19. STREET ADDRESS										20. STREET ADDRESS																			
Md.										Balto.										Reisterstown										2136										2136																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16. SOCIAL SECURITY NO.										17. INFORMANT										18. INFORMANT																			
Maurice C. Erdman										Daisy Irene Mullen										216-10-8182										James T. Dunn										James T. Dunn																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										21. AUTOPSY?										22. AUTOPSY?																			
21a. EXTERNAL CAUSE WAS										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED										22. HOW INJURY OCCURRED										23. HOW INJURY OCCURRED																			
UNDERLYING										HOUR A.M. MONTH DAY YEAR										ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2										ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2										ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2																			
CONTRIBUTING										P.M. 19										21d. PLACE OF INJURY										21e. LOCATION										21f. LOCATION																			
21d. INJURY OCCURRED										21e. PLACE OF INJURY										21f. LOCATION										21g. LOCATION										21h. LOCATION																			
WHILE AT WORK										21f. PLACE OF INJURY										21g. LOCATION										21h. LOCATION										21i. LOCATION																			
21f. PLACE OF INJURY										21g. LOCATION										21h. LOCATION										21i. LOCATION										21j. LOCATION																			
21g. LOCATION										21h. LOCATION										21i. LOCATION										21j. LOCATION										21k. LOCATION																			
21h. LOCATION										21i. LOCATION										21j. LOCATION										21k. LOCATION										21l. LOCATION																			
21i. LOCATION										21j. LOCATION										21k. LOCATION										21l. LOCATION										21m. LOCATION																			
21j. LOCATION										21k. LOCATION										21l. LOCATION										21m. LOCATION										21n. LOCATION																			
21k. LOCATION										21l. LOCATION										21m. LOCATION										21n. LOCATION										21o. LOCATION																			
21l. LOCATION										21m. LOCATION										21n. LOCATION										21o. LOCATION										21p. LOCATION																			
21m. LOCATION										21n. LOCATION										21o. LOCATION										21p. LOCATION										21q. LOCATION																			
21n. LOCATION										21o. LOCATION										21p. LOCATION										21q. LOCATION										21r. LOCATION																			
21o. LOCATION										21p. LOCATION										21q. LOCATION										21r. LOCATION										21s. LOCATION																			
21p. LOCATION										21q. LOCATION										21r. LOCATION										21s. LOCATION										21t. LOCATION																			
21q. LOCATION										21r. LOCATION										21s. LOCATION										21t. LOCATION										21u. LOCATION																			
21r. LOCATION										21s. LOCATION										21t. LOCATION										21u. LOCATION										21v. LOCATION																			
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21v. LOCATION										21w. LOCATION										21x. LOCATION										21y. LOCATION										21z. LOCATION																			
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34. LOCATION										35. LOCATION										36. LOCATION										37. LOCATION										38. LOCATION																			
35. LOCATION										36. LOCATION										37. LOCATION										38. LOCATION																													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMM - 16 50M 4/82

(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lucilla C. Dwyer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>02 07 84</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 17 86</b>		2b. HOUR <b>3:14 PM</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>00 00 00</b>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley View Nursing home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		13a. STREET ADDRESS <b>8720 Emge Road</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Josiah Cowper</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Caffrey</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>--</b>		16b. SOCIAL SECURITY NO. <b>215-10-3537</b>	
17. INFORMANT <b>Mrs. Helen D. Acton</b>		ADDRESS <b>6701 Mt. Vista Rd. Kingsville, Md. 21087</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia @ side</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHF</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Acidosis - Organic Brain Id</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6331 Belair Rd Baltimore Md 21208</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/6/84</b> to <b>2/7/84</b> that (I) (we) last saw the deceased alive on <b>2/6/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Vuong Nguyen</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/8/84</b>	
22d. PHYSICIAN'S NAME (PRINT OR PRINT)		22e. ADDRESS <b>6331 Belair Rd Baltimore Md 21208</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-11-1984</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Episc. Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Kingsville Baltimore Md.</b>		24. FUNERAL DIRECTOR NAME <b>E.F. Lassam</b>		ADDRESS <b>11750 Belair Rd. Kingsville, Md. 21087</b>	

FEB 15 1984 REGISTRAR'S SIGNATURE

SECRET

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

03387

1. DECEASED NAME (TYPE OR PRINT) ROSE CECILIA DYER			2a. DATE OF DEATH MONTH DAY YEAR February 18, 1984			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR January 8, 1902		6. AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 305 E. Joppa Road Apt. 1603				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 305 E. Joppa Road Apt. 1603 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Kavanaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth McCormick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216-36-7676		17. INFORMANT John J. Dyer, III.		ADDRESS 57 Belfast Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal failure 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma, colon 1981									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Sept. 18, 1979, to February 18, 1984, that (I) (we) last saw the deceased alive on February 13, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE Donald O. Wood, M.D.						22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald O. Wood, M.D.						22e. ADDRESS 2 Greenmeadow Drive Timonium, Md. 21093			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 22, 1984		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. Towson, Md. 21204					25a. DATE REC'D. BY REGISTRAR FEB 21 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randell		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Dr. A. J. C. Cook, M.D.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR				REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
FRANK R. EASTMAN				FEBRUARY 19, 1984	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
MALE		WHITE		APRIL 23, 1916	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
KINGSTON, NEW YORK		UNITED STATES		67 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
FORT HOWARD		VA MEDICAL CENTER		BALTIMORE COUNTY MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salesman		Sales			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		P. G. Co.		Hyattsville	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Frank L. Eastman		Helen J. Shull		13e. STREET ADDRESS	
				6103 Sargent Road (20782)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WORLD WAR II 077 10 4063		6103 Sargent Rd. Hyattsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC RESPIRATORY ARREST - INSTANT</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
<u>CEREBRALVASCULAR ACCIDENT; ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>FEBRUARY 1</u> , 19 <u>84</u> , to <u>FEBRUARY 19</u> , 19 <u>84</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>FEBRUARY 19</u> , 19 <u>84</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>P. H. Hung</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		02/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
PO HSLU HUNG, M.D.		VA MEDICAL CENTER, FORT HOWARD, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Feb/21/84		Chambers Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE RECD. BY REGISTRAR			
Riverdale, P.G. Co., Maryland		FEB 27 1984			
24. FUNERAL DIRECTOR NAME ADDRESS		25. REGISTRAR'S SIGNATURE			
Chambers Funeral Home Riverdale, Maryland		<i>John Davidson</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03389

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST <b>Claiborne Livesay Eck</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb 12, 84</b>		2b. HOUR <b>9:21 A.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 19, 1934</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Timonium</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>20 Yorkview Drive, #21093</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Administration</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Office Equip.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Timonium</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Livsay</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia Faulks</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>224-38-1000</b>		17. INFORMANT <b>Husband: M. Bransford Eck, 20 Yorkview Drive, 21093</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Carcinoma of Lung**

DUE TO, OR AS A CONSEQUENCE OF

1629  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**3 1/2 months**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>10/31</b> , 19 <b>83</b> , to <b>2/12</b> , 19 <b>84</b> , that (II) (we) lost saw the deceased alive <b>2/8</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Luke E. Terry Jr.</b>		DEGREE		22c. DATE SIGNED <b>2-12-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Luke E. Terry Jr., MD</b>		22e. ADDRESS <b>9055 Chevrolet Dr, Ellicott City Md 21043</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb 15, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hollywood Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Richmond, Henrico Co, Va.</b>
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>Martin D. Lawson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 11b shows any injury, or other traumatic event, the medical examiner must be notified at once.

March 18, 1924

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03390

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Iola A. ELLIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 18, 1984</b>			2b. HOUR <b>4:15a M</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 02 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MINNESOTA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HAIRDRESSER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HAIR</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>ROSEDALE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8046 PHILADELPHIA RD. 21237</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALFRED ISRAELSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA JOHNSON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>473079880</b>		17. INFORMANT ADDRESS <b>PHILIP ELLIS 8046 PHILADELPHIA RD.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>1629</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cancer of the Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 14, 1984</b> to <b>February 18, 1984</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>February 18, 1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE <b>I. Rodriguez, MD</b>				22c. DATE SIGNED <b>2-18-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Isabel Rodriguez, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>2/20/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. BALTO. MD.</b>
24. FUNERAL DIRECTOR <b>John Cook</b>		25. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>	25. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03391

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Vincent Joseph Flynn</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 19, 1984</b>			2b. HOUR <b>5:46pM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 16, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
12. CITY OR TOWN OF DEATH <b>Rosedale</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cable Operator</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Western Electric</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>		16b. COUNTY <b>Baltimore</b>		16c. CITY OR TOWN <b>Towson</b>		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE <b>1005 Winsford Rd. 21204</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>John T. Flynn, Sr.</b>				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eileen Geary</b>					
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		19c. INFORMANT <b>Norma B. Flynn</b>		19d. ADDRESS <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Failure Secondary to Myocardial Infarction</b> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <b>Femoral - Popliteal Bypass Surgery</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <b>Feb 12</b> , 19 <b>84</b> , to <b>Feb 19</b> , 19 <b>84</b> , that (X) (we) lost saw the deceased alive on <b>Feb 19</b> , 19 <b>84</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.									
22b. SIGNATURE <b>P. A. Baltatzis</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/19/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Panayotis A. Baltatzis, M.D.</b>			22e. ADDRESS <b>9000 Franklin Square Dr. 21237</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 22, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium, Balto. Co., Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md.</b>			ADDRESS <b>6500 York Rd.</b>		25. DATE REC'D. BY REGISTRAR <b>FEB 23 1984</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other", item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Harry V. Eminger</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 4, 1984</b>			2b. HOUR <b>7:45 AM</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 27, 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welding Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth Steel</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4314 Parkwood Ave. 21206</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lorenzo B. Eminger</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mae McCutcheon</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-07-5686</b>		17 INFORMANT ADDRESS <b>Frank B. Eminger 171 Meadow Rd. Pasadena, Md. 21122</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100 Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>polyarteritis venosa</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1981</b> , 19____, to <b>2/4</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/4</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>ant Serpiek</b>			DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>2/7/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur Serpiek, M.D.</b>			22e. ADDRESS <b>2360 W. Joppa Road Lutherville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 8, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>				
					25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>				

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FEB 8 1944



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET</b> <b>S.</b> <b>ENEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 28, 1984</b>			2b. HOUR <b>11:55 PM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPTEMBER 11, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN NURSING CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OWN HOME</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE T. SWAYNE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET DURHAM</b>			16. STREET ADDRESS / ZIP CODE <b>1918 OLD FREDERICK ROAD 21228</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-18-5925</b>		17. INFORMANT ADDRESS <b>MARGARET GORDY 1918 OLD FREDERICK ROAD 21228</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>old Age; ASCVD; Diabetes Mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>few years</b> to <b>2/28/84</b> , that (I) (we) lost saw the deceased alive on <b>2/28/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>BARB Y. RAO</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2.28.84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARB Y. RAO</b>			22e. ADDRESS <b>MD 8811 LIBERTY ROAD RANDALLSTOWN MARYLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>3/3/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		
24. DEPOSITORY OF RECORDS <b>DEROY &amp; RUSSELL WITZKE FUNERAL HOMES</b> <b>1630 EDMONDSON AVENUE BALTO. MARYLAND 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers Pages 1 and 2 and file them in the file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Page 11      Date, 1st December      No.      =      1

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03394			
1. DECEASED NAME [TYPE OR PRINT] <b>THOMAS J ENNIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>02 05 84</b>			
3. SEX <b>Male</b>				4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 30. 1893</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b>		7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Office</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;ORR</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas J.J. Ennis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice M. Swann</b>		13e. STREET ADDRESS / ZIP CODE <b>1179 East Northern Pkwy 21239</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>705-05-4163</b>		17. INFORMANT ADDRESS <b>Mary J. Vito 3114 Woodring Ave. 21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5314</b> IMMEDIATE CAUSE (a) <b>Bleeding stress gastric ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Peptic ulcer (d) Arteriosclerotic</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Cardiovascular Disease</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 23</b> 19 <b>84</b> , to <b>Feb. 5</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>Feb. 5</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>B. J. Velez, M.D.</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-5-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Velez, Baltasar B</b>				22e. ADDRESS <b>7620 York Road, Towson, Md. - 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 9 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 7 1984 John J. Conner</b>			

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Cardiomyopathy Disease  
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Lymphatic (4) Arteriosclerotic  
Lymphatic (4) Arteriosclerotic

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 03395				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Catherine S. ERAUTH					2a. DATE OF DEATH MONTH DAY YEAR 2/15/84			2b. HOUR MIN. 6:25 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 25, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 92		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Salvage	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13. STREET ADDRESS / ZIP CODE 6820 Boston Ave. #21222			
14. FATHER'S NAME FIRST MIDDLE LAST Louis Sauer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella unk.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-09-1520			17. INFORMANT ADDRESS Frank Eraith - 6820 Boston Ave. #21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from February 3, 1984, to February 15, 1984, that (I) (we) last saw the deceased alive on February 15, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after burial.									
22b. SIGNATURE Joseph A. Schneider, M.D.						22c. DATE SIGNED 2/15/84		22d. ADDRESS 9000 Franklin Square Drive - 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/18/84		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME George A. Weber & Sons Inc. - 705 S. Ann St.						25a. DATE REC'D. BY REGISTRAR FEB 17 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03396

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANGELINA ERCOLANO</b>			2a. DATE OF DEATH MONTH <b>02</b> DAY <b>03</b> YEAR <b>84</b>			2b. HOUR <b>5:19 PM</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>White CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>10</b> YEAR <b>96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS. HOURS <b>00</b> MIN. <b>00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET <b>2804 Pelham Avenue</b> <b>21213</b> <b>6000 BELLENA AVE</b>			
14. FATHER'S NAME FIRST <b>Salvatore</b> MIDDLE <b>Romano</b> LAST <b>Romano</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Louise</b> MIDDLE <b>Maresca</b> LAST <b>Maresca</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>213-28-3824</b>		17. INFORMANT ADDRESS <b>Salvatore P. Ercolano 1309 Glendale Road 21239</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

5570

IMMEDIATE CAUSE (a) **Cardiovascular Failure.**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Metabolic Acidosis & shock.**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Mesenteric Thrombosis.**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**Uncontrolled Diabetes Mellitus.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>F. A. Bohorquez</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/9/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F. A. Bohorquez</b>		22e. ADDRESS <b>7401 OSTER DRIVE.</b>					

23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>2-6-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>Towson, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 7 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, however, injury, or other traumatic event, the medical examiner must be notified at once.

BP

ANGELINA - ESCOLANO

BALTIMORE COUNTY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/interment permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, no medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03397

FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVELYN FARBER				2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 23, 1984		2b. HOUR 10:30 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 28, 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST MEYER BLUMBERG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IDA ESTHER BOONE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-07-9209		17. INFORMANT ADDRESS REISTERSTOWN, MD 21136 MRS. ILENE ROSENZWEIG 100 SUNNYMEADOW LANE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCLVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 hrs</i> <i>10 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Chronic Lymphatic Leukemia - Pneumonia</i>							
19a. DATE OF OPERATION <i>none</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>6/24 83</i> <i>2/23 84</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/24 83</i> to <i>2/23 84</i> , that (I) (we) last saw the deceased alive on <i>2/23 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Maurice Feldman</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/28/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR MAURICE FELDMAN JR				22e. ADDRESS <i>6610 CROSS COUNTRY BLVD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/26/84		23c. NAME OF CEMETERY OR CREMATORY ANSHE NEISEN CEM		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215				25a. DATE REC'D. BY REGISTRAR FEB 29 1984			

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03398

FOR  
1 - STATE  
REGISTRAR

REG. NO.

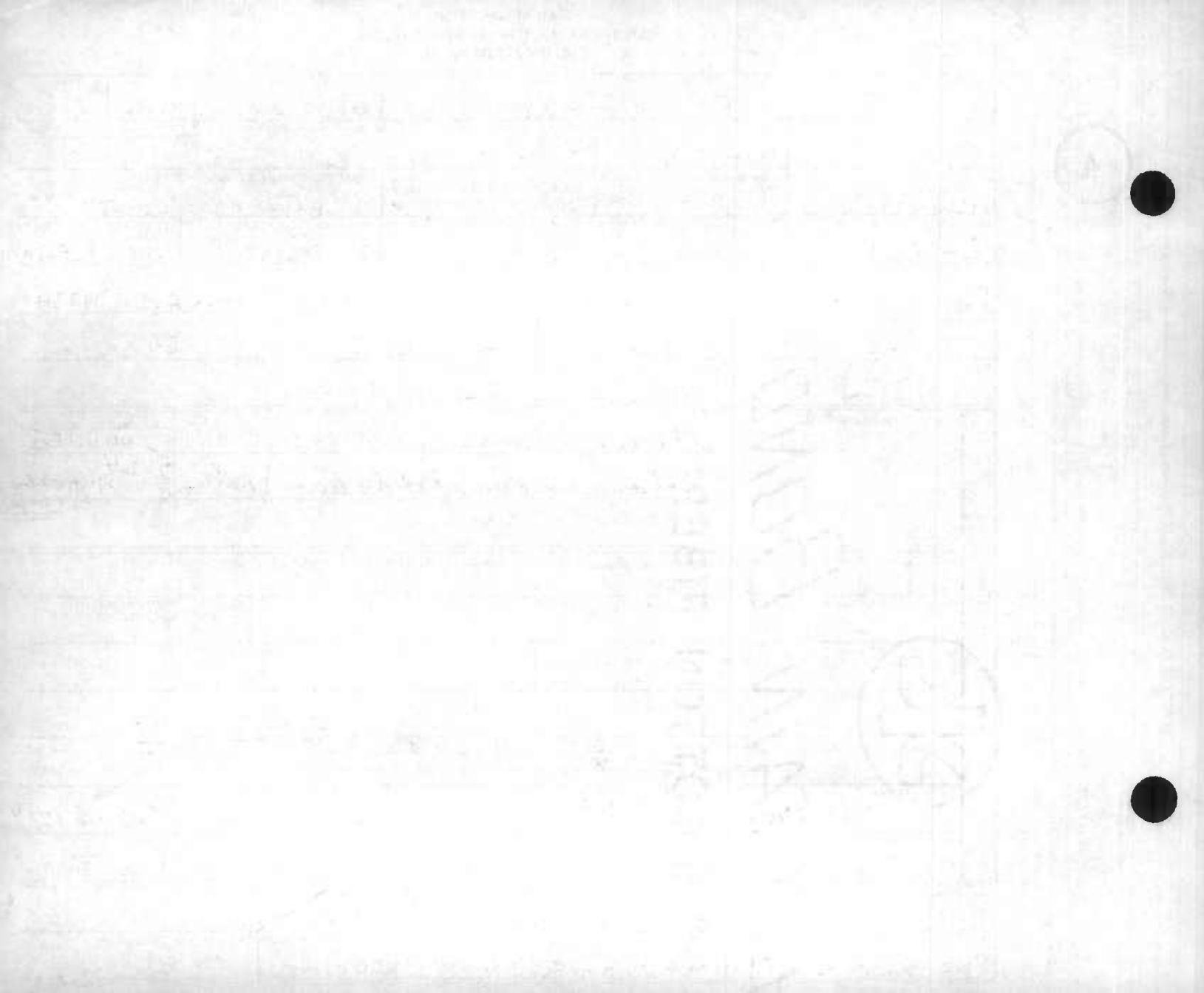
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John F. FARINO			2a DATE OF DEATH MONTH DAY YEAR FEBRUARY 13, 1984		2b. HOUR M
3. SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 19, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10 CITY OR TOWN OF DEATH CARNBY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9642 MASON AVE.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMP.		12b. KIND OF BUSINESS OR INDUSTRY SHOE REPAIR
13a. STATE Maryland	13b. COUNTY BALTIMORE	13c. CITY OR TOWN CARNBY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9642 MASON AVE. 21234
14 FATHER'S NAME FIRST MIDDLE LAST STEPHAN S. FARINO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANGELINA GUERCI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217 072056		17. INFORMANT ADDRESS FAMILY RECORDS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 1552 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of abd (liver), metastatic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5-24 months in stage</u> Approximate interval between onset and death: <u>5-24 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Feb 13 84	
22a. I certify that (I) (this hospital) attended the deceased from Oct 19, 1983, to Feb 13, 1984, that (I) (we) last saw the deceased alive on Dec 12, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ruben [Signature] MD		DEGREE MD		22c. DATE SIGNED Feb 16 1984	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOHN R. SAUNDERS		22e. ADDRESS 1001 Cromwell BRIDGE ROAD, Towson			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 16 1984		23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		23e. DATE REC'D. BY REGISTRAR FEB 21 1984			
24 FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES HARFORD ROAD		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03399

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Lydia M Feeser</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>2 22 84</i>		2b. HOUR <i>7:30 PM</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>9 2 1887</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>100</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (COUNTRY) <i>Baltimore</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Balto</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Manor Care Rosville</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Unknown</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>HSHW</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Balto</i>	13c. CITY OR TOWN <i>MIDDLE RIVER</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>56 W. Kingston Park La</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Amos Lightner</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown ALICE BLOUGH</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>214-74-8146</i>		17. INFORMANT ADDRESS <i>Alice Peters 56 W. Kingston Park La</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>yes.</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 hr.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Senile Dementia.</i>					
19a. DATE OF OPERATION <i>2/22/84</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Senile Dementia</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>6/30/1980</i> to <i>2/22/1984</i> , that (I/we) lost saw the deceased alive on <i>2/22/1984</i> and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William M. Tun</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>2/22/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William M. Tun</i>		22e. ADDRESS <i>Manor Care Rosville md 21237</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>2/25/84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>GARDENS OF FAITH</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTO. MD.</i>
24. FUNERAL DIRECTOR NAME <i>J. G. CORNELLY</i>		ADDRESS <i>300 MAC</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 1 1984</i>	25b. REGISTRAR'S SIGNATURE <i>John A. ...</i>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN H. FERBER JR.			2a. DATE OF DEATH MONTH DAY YEAR February 15, 1984			2b. HOUR a. M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lt. Balt. City		12b. KIND OF BUSINESS OR INDUSTRY Fire Dept.	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Rosedale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John H. Ferber Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura V. Cavey <sup>ST</sup>		13e. STREET ADDRESS 1520 Customs Road 21237			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-18-0483		17. INFORMANT ADDRESS Zena M. Ferber 1520 Customs Rd. 21237			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction with high grade AV block. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8-26, 19 75, to 2-15, 19 84, that (I) (we) last saw the deceased alive on 2-8, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE Dr. Rafael Perez-Mera				DEGREE M.D.		22c. DATE SIGNED 15 Feb 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Rafael Perez-Mera M.D.				22e. ADDRESS 5400 Old Court Rd. Randallstown, Md. 21233			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 18 1984		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 18 1984		25b. REGISTRAR'S SIGNATURE ne Davidson-Randall	







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03401

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM H. FISHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 5 84</b>			2b. HOUR <b>5 P</b> M	
3. SEX <b>M</b>		4. RACE <b>CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 15 19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STEEL WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BETHLEHEM STEEL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE FISHER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE CASSIDY</b>		13e. STREET ADDRESS / ZIP CODE <b>3383 DULANEY STREET, 21229</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 218-05-4851</b>		17. INFORMANT ADDRESS <b>VIRGINIA G. FISHER 3383 DULANEY ST. 21229</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>not well carcinoma of the lung</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>possible pulmonary embolism</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> 19 <b>84</b> , to <b>Feb</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>Feb 5</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>and absent</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/5/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur A Scarpillo</b>		22e. ADDRESS <b>St. Joseph Hosp Towson MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>02-07-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>		ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		February 16, 1984		10 P.M.	
WALTER E. FLEISCHER, SR. M.D.							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		MONTH DAY YEAR March 5, 1908		75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New York		U.S.A.				Baltimore County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Manor Care Towson		Physician - Bethlehem Steel			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Frank G. Fleischer		Nettie R. Hitzel		Yes		091-19-6382	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Aspiration - chronic</u> (c) <u>Multiple CVA's</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Days 6 Months 4 yrs	
Mrs. Nita M. Fleischer, same as #13e							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCVD, Renal Failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> , 19 <u>83</u> , to <u>2/16</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/13/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>William H. Goldiner, M.D.</u>		22c. DATE SIGNED <u>2/17/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
William H. Goldiner, M.D.		54 Scott Adam Rd., Cockeysville, Md.		Burial		2-20-84	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Dulaney Valley Cem.		Cockeysville, Maryland		Ruck Towson Funeral Home, Inc.		FEB 21 1984	
25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>				25c. REGISTRAR'S SIGNATURE			

TO: THE SECRETARY OF THE ARMY

FROM: THE CHIEF OF THE BUREAU OF MILITARY HISTORY

SUBJECT: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosa Follmer				2a. DATE OF DEATH MONTH DAY YEAR 02 29 84			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 07 23 98		6. AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Ct. Catonsville		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Clothing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13e. STREET ADDRESS / ZIP CODE 12 Wyndcrest Avenue, 21228	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Follmer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaretha Hanitsch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-20-9055		17. INFORMANT ADDRESS Lisette Thompson 12 Wyndcrest Ave., 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 days 3 weeks							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>88</u> , to <u>Feb 29</u> 19 <u>89</u> , that (I) (we) lost saw the deceased alive on <u>2-24</u> 19 <u>89</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE David R. Moser M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 2-29-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David R. Moser, M.D.				22e. ADDRESS 5205 East Dr. Arbutus, Md. 21227			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03-03-84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR MAR 2 1984		25b. REGISTRAR'S SIGNATURE John Davidson	

3

10-10-10  
MAR 2 1911



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03404

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LENA ELIZABETH FONES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 4, 1984</b>		2b. HOL <b>4:40 AM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 9, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1 RIDGE ROAD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MEDICAL SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>CATONSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1 RIDGE ROAD CATONSVILLE 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JESSE WYATT</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAUD EDDINS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-03-1066</b>		17. INFORMANT ADDRESS <b>NANCY BELLIS 1 RIDGE ROAD CATONSVILLE MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>lung carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>8 mo.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 4/80</b> 19 <b>83</b> to <b>2/4</b> 19 <b>84</b> , the <b>(11)</b> (we) last saw the deceased alive on <b>4/30</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>William C. Waterfield</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>2/4/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM C. WATERFIELD</b>		22e. ADDRESS <b>900 Caton Avenue Baltimore Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/7/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>
24. FUNERAL DIRECTOR <b>LEROY &amp; RUSSELL WITZKE FUNERAL HOMES P.A.</b>			25a. DATE REC'D. BY REG. IN PAR. 25b. REG. TRANS. SIGNATURE <b>FEB 6 1984</b>		
25. ADDRESS <b>1630 EDMONDSON AVENUE BALTIMORE MARYLAND 21228</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





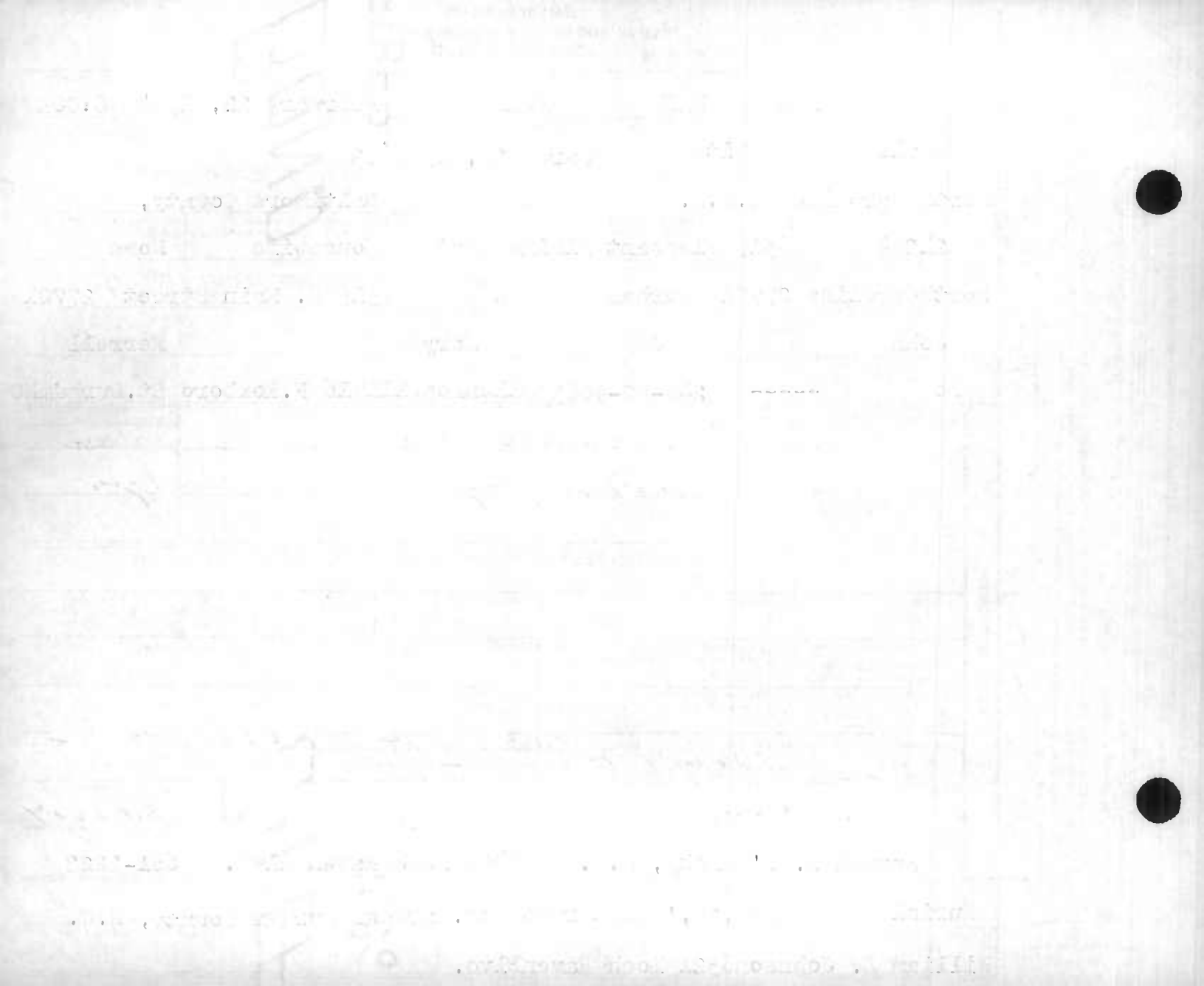
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner number should be filled at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										03405	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>GOLAR MAE FORD</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>February 22, 1984</b>			2b. HOUR <b>6:00AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 25, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>21204</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8519 Pleasant Plains Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>North Carolina</b>					13b. COUNTY <b>27701</b>		13c. CITY OR TOWN <b>Durham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Gay</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ferrell</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>240-92-9083</b>		17. INFORMANT ADDRESS <b>Ellen Powell 11716 N. Roxboro St. Durham NC</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a) <b>Cardiocardiac Collapse</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cocaine &amp; lung.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 year</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>1 year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 3</b> , 19 <b>84</b> , to <b>Feb 22</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>February 16</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Samuel I. O'Mansky</b>				DEGREE				22c. DATE SIGNED <b>Feb 22 1984</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Samuel I. O'Mansky, M.D.</b>				22e. ADDRESS <b>8405 Loch Raven Blvd. 661-2222</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Feb. 24, '84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Durham County, N.C.</b>			
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>				ADDRESS <b>8521 Loch Raven Blvd.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1984</b>		25b. REGISTRAR'S SIGNATURE			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03406

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jeannette Katherine Foster			2a. DATE OF DEATH MONTH DAY YEAR February 23, 1984			2b. HOUR 4:10 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 6, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Sparks		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Md. 914 Lower Glenco Rd., Sparks		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Sparks		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Kraus		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Harriet Kurtz		13e. STREET ADDRESS / ZIP CODE Md. 21130 914 Lower Glenco Rd., Sparks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- --		17. INFORMANT ADDRESS Rd. Sparks, 21130 Mr. E. Levering Foster, 914 Lower Glenco			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Advanced Diffuse Histiocytic Lymphoma</u> <u>2000</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nbv</u> , 19 <u>82</u> , to <u>Feb 23</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Feb 11</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Charles Padgett</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/27/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Padgett, M. D.				22e. ADDRESS Good Samaritan Prof. Bldg, Suite 107 5601 Loch Raven Blvd., 21239			

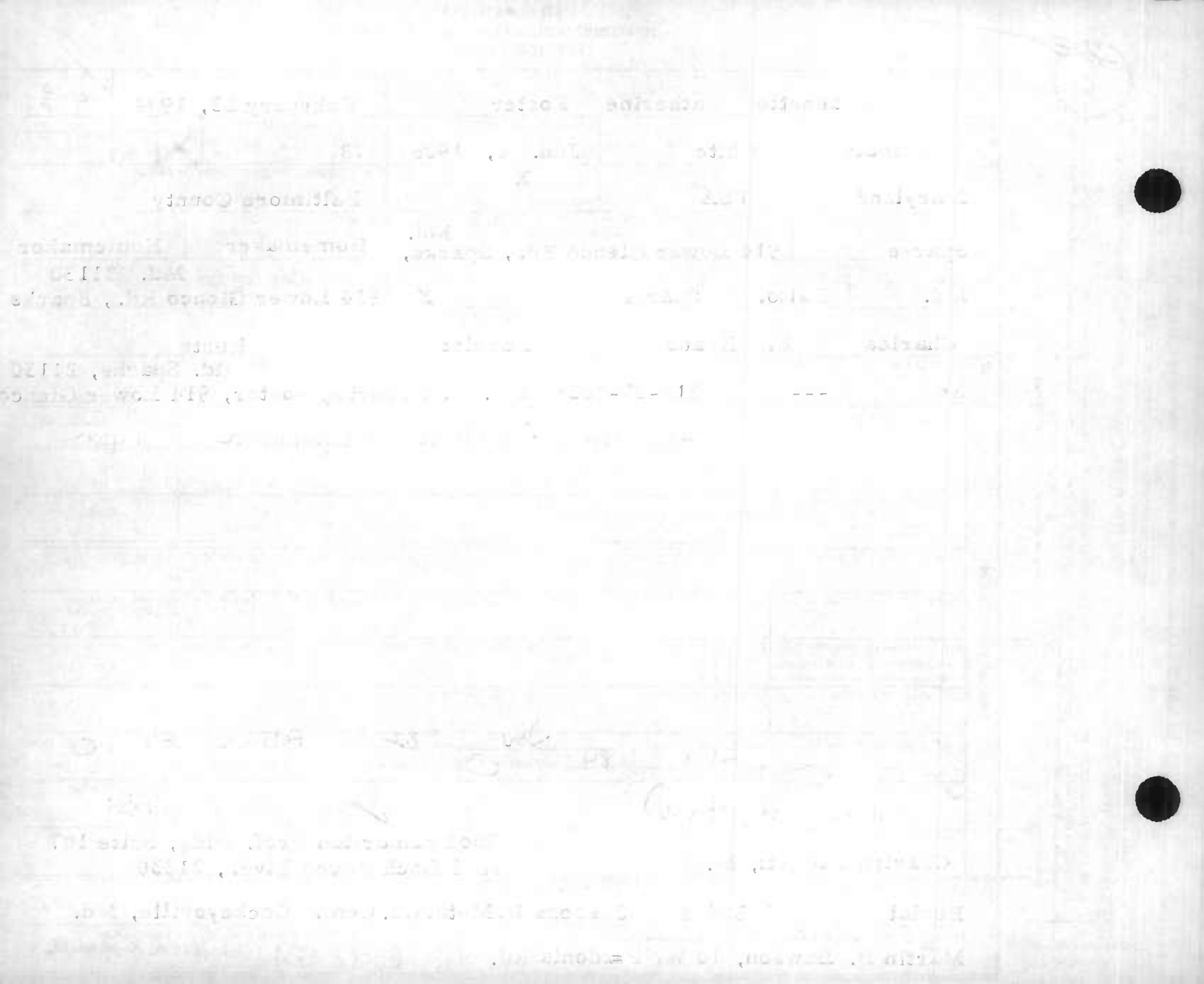
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/84		23c. NAME OF CEMETERY OR CREMATORY Jessops U. Meth. Ch. Cem. Cockeysville, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Martin D. Lawson, 10 W. Padonia Rd.				25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

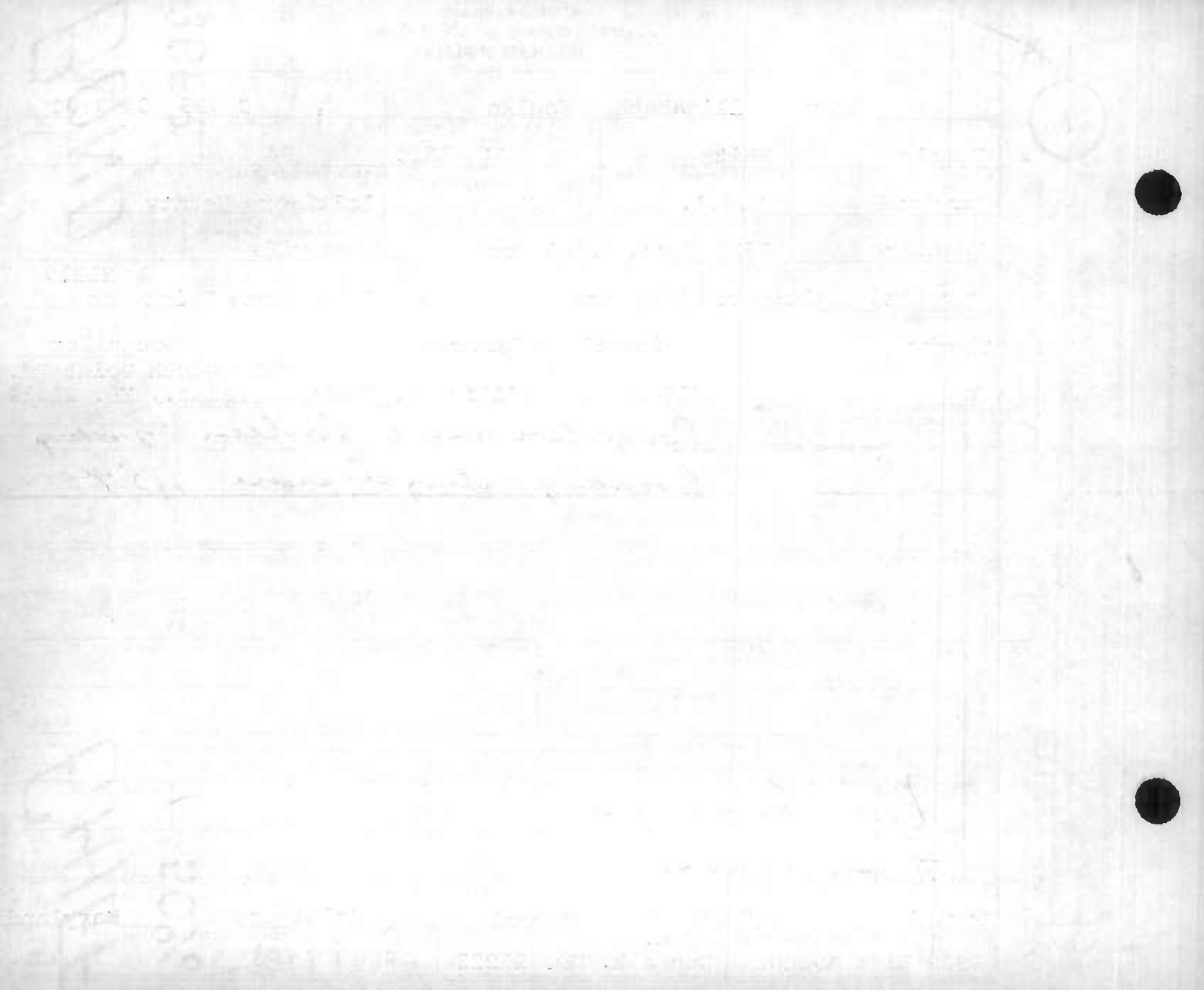
1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Clara Elizabeth Foulke			2a. DATE OF DEATH MONTH DAY YEAR 2 15 84			2b. HOUR A 3:00 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 26 1889		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Edgemere		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7929 North Point Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 7929 North Point Road 21219			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Edgemere		13f. STREET ADDRESS / ZIP CODE 7929 North Point Road 21219			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Fitzell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Lohmuller			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 218-14-2909			17. INFORMANT ADDRESS 7929 North Point Rd. William E. Foulke Balto., MD. 21219			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart failure</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>15 years</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>15 years</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <i>John V. Conway</i>			DEGREE			22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN V. CONWAY	
22e. ADDRESS			22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 2/17/1984			23c. NAME OF CEMETERY OR CREMATORY Parkwood			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222			25a. DATE REC'D. BY REGISTRAR FEB 17 1984			25b. REGISTRAR'S SIGNATURE <i>John V. Conway</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03408

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>FRANCIS ADDISON FOWLER</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>2-18-84</u>			2b. HOUR <u>12<sup>55</sup> P.M.</u>	
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>June 19, 1902</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>81</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Baltimore, Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County, MD.</u>	
10. CITY OR TOWN OF DEATH <u>Catonsville,</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Summit Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Insurance Agent</u>	
13a. STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Catonsville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Alexander -- Fowler</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Frances A. Stewart</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>215-03-3866</u>		17. INFORMANT <u>Catonsville, Md. 21228. Rd.</u> <u>Mrs. Gertrude C. Fowler-303 Patleigh</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) ASCVD

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Parkinsonism, Old CVA - rgt hemiparesis

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>15 Nov</u> , 19 <u>82</u> , to <u>18 Feb</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>17 Feb</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James E. Rowe</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>2/18/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J. E. ROWE</u>		22e. ADDRESS <u>Summit Nursing Home</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>2/22/84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem. - Baltimore, Md.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <u>Sterling Funeral Estate, P.A.</u> <u>736 Edmondson Ave.; Catonsville, Md. 21228</u>				25a. DATE REC'D. BY REGISTRAR <u>FEB 21 1984</u>		25b. REGISTRAR'S SIGNATURE <u>J. Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 5-72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

3

EX





STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

03409

 1- FOR  
 STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Howard Frank			2a. DATE OF DEATH MONTH DAY YEAR 02 06 84			2b. HOUR A 9:30 M					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 02 12 03		6. AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Ct. Catonsville				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman		12b. KIND OF BUSINESS OR INDUSTRY Balto. City Police			
13a. STATE MD			13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 802 Southridge Rd. 21228		
14. FATHER'S NAME FIRST MIDDLE LAST James Frank				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-05-0062		17. INFORMANT ADDRESS William Clark 802 Southridge Rd. 21228						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVD - death in hospital L PRD</u> <u>4280</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>SECOND CVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ROD - M.D.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7-15-82</u> , 19 <u>82</u> , to <u>2-6-84</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-6-84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2-6-84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GEORGE DARGOC</u>				22e. ADDRESS <u>3350 Wilkins Dr - Baltimore</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/9/84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR FEB 8 1984			
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with #12 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 4.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03410

1- FOR  
STATE  
REGISTRAR

REG. NO.

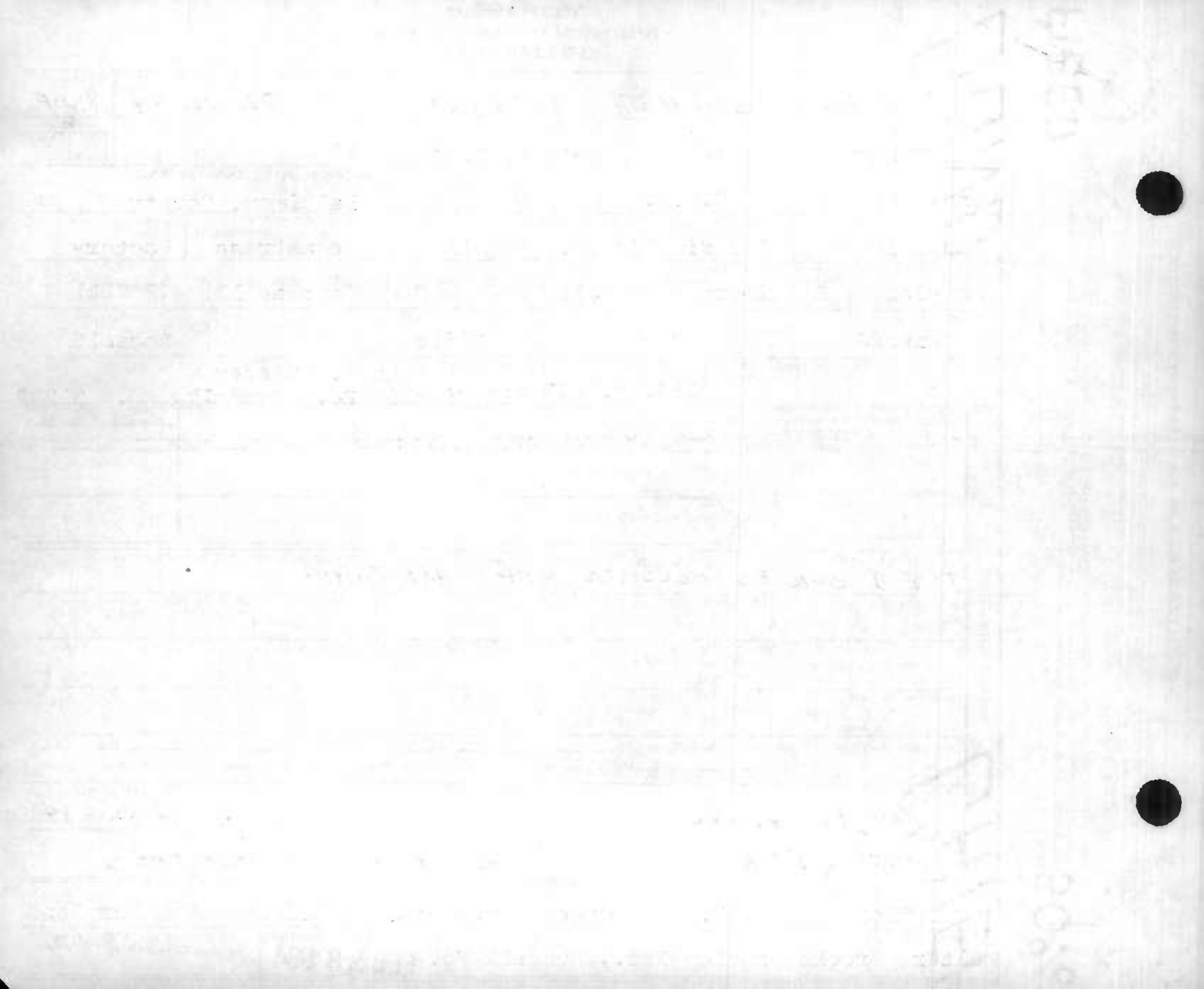
1. DECEASED NAME (TYPE OR PRINT) <b>EMILIE ELIZABETH FREDERICK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>02 26 84</b>			2b. HOUR <b>8:00 P.M.</b>				
3. SEX <b>F Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bonn, Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>119 Kinship Rd., Apt 1A</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Same as 11 (21222)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernard Gath</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emile Bocsolet</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214.20.1037</b>		17. INFORMANT ADDRESS <b>John R. Prosser</b> <b>113 Kinship Rd., Dundalk, Md. 21222</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>TYPE II DIABETES MELLITUS; CHF; ARRHYTHMIA</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Mary Korytkowski</b>			DEGREE			22c. DATE SIGNED <b>2-26-84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARY KORYTKOWSKI</b>			22e. ADDRESS <b>BALTIMORE CITY HOSPITALS</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>2.27.1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley Inc., Dundalk Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1984</b>			25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "injury," or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Rose Elizabeth Freeman					Feb. 15 84	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		2b. HOUR A.M.
Female		Caucasin		3 28 1895		8:00 A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.
Maryland		U.S.A.				9. BALTIMORE CITY OR COUNTY OF DEATH
Catonsville		Meridian Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Housewife		Home				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12c. STREET ADDRESS	
Catonsville			Meridian Nursing Home		25 Summerset Road 21228	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS	
Md. Balto.			Catonsville		25 Summerset Road 21228	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
William Knight			Caroline Leyhe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No			214-64-8853		296 Bloomsbury Ave. Apt A-12	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cerebrovascular disease</u>						
4370 DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
(b) _____						
DUE TO, OR AS A CONSEQUENCE OF						
(c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <del>XX</del> this hospital) attended the deceased from <u>3/23/81</u> , 19____, to____, 19____, that <del>X</del> (we) lost saw the deceased <u>we</u> <u>2/9/84</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE				DEGREE		22c. DATE SIGNED
Laurence R. Gallagher, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2-16-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
Laurence R. Gallagher, M.D.				3455 Wilkens Avenue Balto. Md. 21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		2-18-84		Loudon Park Cem.		Baltimore Md.
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR		
MacNabb Funeral Home				Feb 21 1984		
Catonsville Md.				BALTIMORE REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										03412		
1. FOR STATE REGISTRAR										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE E. LAST FULTON					2a. DATE OF DEATH MONTH DAY YEAR February 5, 1984			2b. HOUR 2:30 P M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.						
10. CITY OR TOWN OF DEATH Maryland Line		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 21418 York Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none			12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Maryland Line		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21418 York Rd. 21105	
14. FATHER'S NAME FIRST Chester MIDDLE Lee LAST Fulton					15. MOTHER'S MAIDEN NAME FIRST Lillie MIDDLE Mae LAST Sykes							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS 21418 York Rd. Louise E. Fulton, Maryland Line, MD 21105								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) <u>Angiogram heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 78 hours												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Carcinoma of the colon</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> 19 <u>84</u> <u>4/5</u> 19 <u>83</u> , to <u>7/26</u> 19 <u>83</u> , that (I) (we) lost <u>saw the deceased alive or above</u> (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Mark S. Kaplan			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2/8/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK S. KAPLAN M.D.			22e. ADDRESS 16918 York Rd. Monkton Md 21111									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 8, 1984		23c. NAME OF CEMETERY OR CREMATORY Maryland Line Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Maryland Line, Balto., MD				
24. FUNERAL DIRECTOR J. J. Hartenstein			Second at Franklin St New Freedom, PA 17349			25a. DATE REC'D. BY REGISTRAR FEB 22 1984			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO

LIBRARY OF THE UNIVERSITY OF CHICAGO  
540 EAST 58TH STREET  
CHICAGO, ILL. 60637

DATE: 10/10/77  
BY: [illegible]  
RE: [illegible]

TO: [illegible]  
FROM: [illegible]

SUBJECT: [illegible]

REMARKS: [illegible]

APPROVED: [illegible]

SPECIAL AGENT IN CHARGE

U.S. DEPARTMENT OF JUSTICE

10-10-77





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows prior injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				03413 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Clara Belle Furstenberg</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 17 '84</b>				2b. HOUR <b>7<sup>25</sup> PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 28 92</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Ruxton</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>In Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>115 Industrial Blvd. 21502</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Rice</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Smeltzer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>176-44-3341</b>		17. INFORMANT ADDRESS <b>Mrs. Mary Jane Mullan, Flintstone, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic (cardiovascular) disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 27<sup>th</sup> 1970</b> to <b>Feb 17<sup>th</sup> 1984</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>12/1/83</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(do not)</del> view the body after death.											
22b. SIGNATURE <b>M. Kevin Quinn</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/18/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. KEVIN QUINN MD</b>				22e. ADDRESS <b>1205 YORK RD, LUTHERVILLE MD 21093</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>				23b. DATE <b>2-20-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cumberland, Allegany, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>James F. Scarpelli, Cumberland, Md.</b>				25a. DATE OF BURIAL <b>FEB 27</b>		25b. REGISTRAR SIGNATURE <b>James Scarpelli</b>					

BP

Handwritten notes and diagrams at the top of the page, including a large 'X' and various scribbles.

Corporate with address  
1234 Main Street  
City, State, Zip

12/12/81  
M. Kevin Quinn MD  
1200 York Rd  
Baltimore, MD 21202  
7-50-34  
James J. Connelly, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

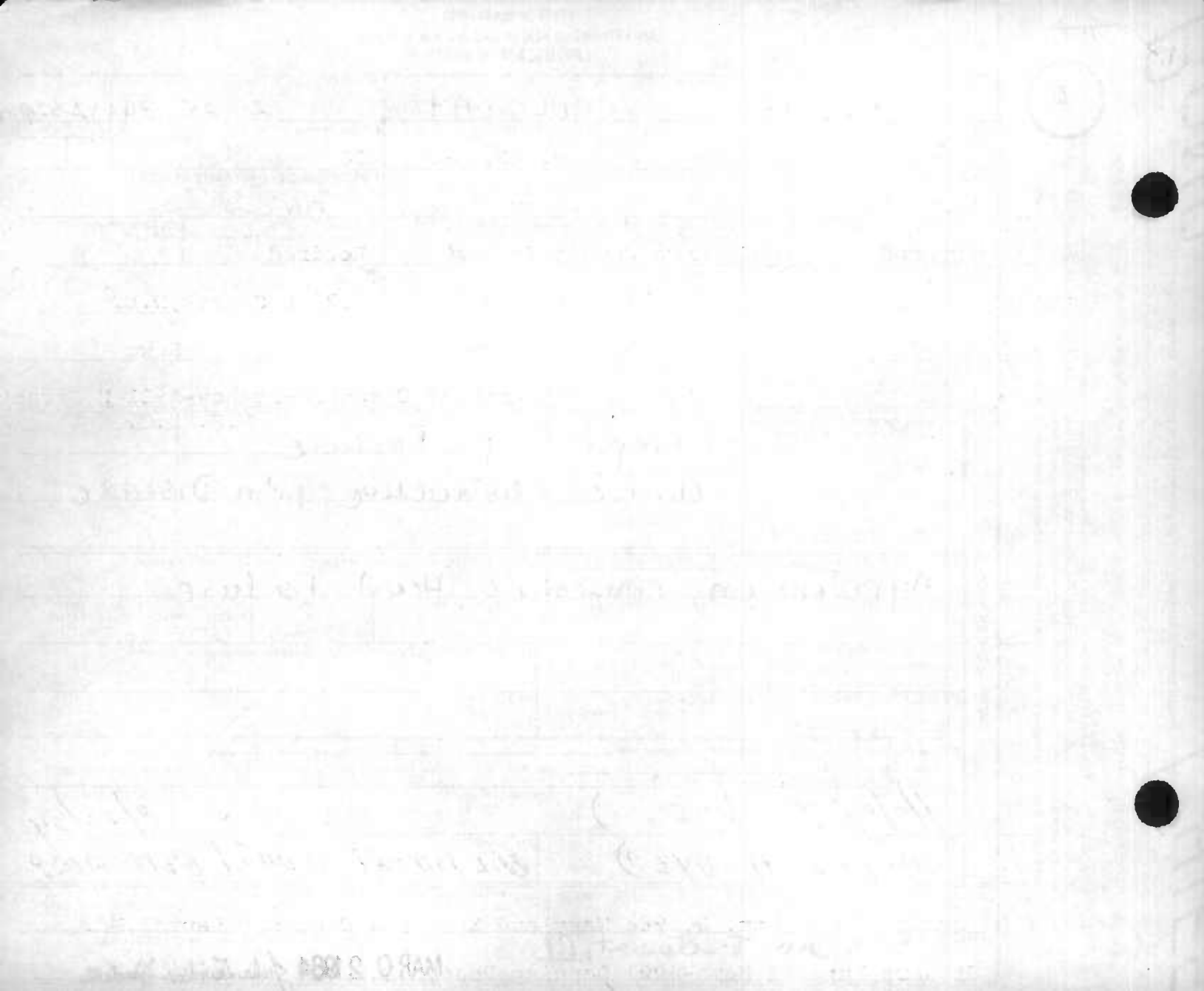
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

03414

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST NELLIE GALLOWAY			MONTH DAY YEAR 2 25 84			12:52 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))			7. IF UNDER 1 YEAR		
Female	Black	MONTH DAY YEAR Dec. 23, 1905	78 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia	USA		BALTO Co. MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Maryland	Baltimore County General			Retired				
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE		
District of Columbia			Washington			1921 H Street, N.E. 99999		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Calvin Cheatham			FIRST MIDDLE LAST Mary Rowe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
no			577 12 4019			Garrett Cheatham-nephew-1921 H Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> N.E. D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
4960 DUE TO, OR AS A CONSEQUENCE OF								
(b) <u>Chronic Obstructive Pulm Disease</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
<u>Hypotension, Congestive Heart Failure</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
HAFFEEZ A SYED						2/25/84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
HAFFEEZ A SYED			BALTIMORE COUNTY GEN HOSP					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			Mar. 2, 1984			Maryland National Cemetery Laurel, Md.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John T. Stewart, II			MAR 2 1984			John T. Stewart, II		
Stewart Funeral Home-4001 Benning Road								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mrs. Meda Kay Gates</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 26 1984</b>			2b. HOUR M <b>A</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 3 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>89</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Westview</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5632 Johnnycake Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Statistician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Agricultur</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>5632 Johnnycake Rd. 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William E. Kay</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Adela Mead</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-40-6222</b>		17. INFORMANT <b>Mrs. Almeda Clough</b>		ADDRESS <b>5632 Johnnycake Rd. Baltimore Maryland</b>		21207	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old age, H.A.S.C.V.D., C.C.H.F.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/24/84</b> to <b>2/26/84</b> , that (I) (we) last saw the deceased alive on <b>2/24/84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Babu Y. Rao</b>				22c. DATE SIGNED <b>2/26/84</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Babu Y. Rao</b>				22e. ADDRESS <b>8811 Liberty Road Randallstown, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>03-01-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Herikimer Herikimer New York</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			
8728 Liberty Road Randallstown, Maryland 21133									

MEDICAL CERTIFICATION

BP

THE UNIVERSITY OF CHICAGO  
LIBRARY

January 29 1957

Mr. John Jay Jones

Dear Mr. Jones:

I have just received your letter of January 24, 1957, regarding the matter of the University of Chicago Press. I am sorry that I cannot give you a more definite answer at this time, but I am sure that you will understand my position.

I am, very respectfully,  
Yours truly,  
[Signature]

Very truly yours,  
[Signature]

Enclosed for you are two copies of the report of the Committee on the University of Chicago Press, dated January 18, 1957.

I am sure that you will find this report of interest and that it will help you to understand the situation at the University of Chicago Press. I am sure that you will find it of interest and that it will help you to understand the situation at the University of Chicago Press.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked as item 18 about any injury, or other traumatic event, the medical examiner must be notified thereof.

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
EUGENE E. GELHAUS				2 5 84				8:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
MALE		WHITE		4 2 02		81 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Catonsville		Frederick Villa Nursing Home				Carrier		U.S. Postal Svc.			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		425 Rosecroft Terrace 21229	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Frederick Wm. Gelhaus				FIRST MIDDLE LAST Antoinette Wren							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO				212-36-5782		Dr. Vernon M. Gelhaus 2108 Cedar Circle 21228					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4860 Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Potential Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pargaparesis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Pargaparesis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/4</u> 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(initials)</u> (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>James Nolan MD</u>										<u>2/6/84</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				2/7/84		Loudon Park Maus.		Baltimore Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				FEB 8 1984		<u>John J. Carver</u>					



1. Name of the person or organization 2. Address 3. City 4. State 5. Zip		6. Date 7. Time	
8. Subject 9. Description of the event or activity		10. Remarks	
11. Name of the person or organization 12. Address 13. City 14. State 15. Zip		16. Date 17. Time	
18. Subject 19. Description of the event or activity		20. Remarks	
21. Name of the person or organization 22. Address 23. City 24. State 25. Zip		26. Date 27. Time	
28. Subject 29. Description of the event or activity		30. Remarks	
31. Name of the person or organization 32. Address 33. City 34. State 35. Zip		36. Date 37. Time	
38. Subject 39. Description of the event or activity		40. Remarks	
41. Name of the person or organization 42. Address 43. City 44. State 45. Zip		46. Date 47. Time	
48. Subject 49. Description of the event or activity		50. Remarks	
51. Name of the person or organization 52. Address 53. City 54. State 55. Zip		56. Date 57. Time	
58. Subject 59. Description of the event or activity		60. Remarks	
61. Name of the person or organization 62. Address 63. City 64. State 65. Zip		66. Date 67. Time	
68. Subject 69. Description of the event or activity		70. Remarks	
71. Name of the person or organization 72. Address 73. City 74. State 75. Zip		76. Date 77. Time	
78. Subject 79. Description of the event or activity		80. Remarks	
81. Name of the person or organization 82. Address 83. City 84. State 85. Zip		86. Date 87. Time	
88. Subject 89. Description of the event or activity		90. Remarks	
91. Name of the person or organization 92. Address 93. City 94. State 95. Zip		96. Date 97. Time	
98. Subject 99. Description of the event or activity		100. Remarks	

101. Name of the person or organization  
 102. Address  
 103. City  
 104. State  
 105. Zip



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary E Gempp			2a. DATE OF DEATH MONTH DAY YEAR 02 09 84			2b. HOUR A 1100 M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 4, 1895		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 23 HRS. 88 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 5810 Windsor Mill Road 21207		14. FATHER'S NAME FIRST MIDDLE LAST Daniel Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Rittler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220-54-9153		17. INFORMANT Elizabeth Gempp, 5810 Windsor Mill Road		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA.</u> <u>2500</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASHD. Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-16-84</u> , 19 <u>84</u> , to <u>2-1-84</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>2-1-84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Nevzat Turkman</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/10/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nevzat Turkman, M.D.				22e. ADDRESS 10706 Reisterstown Road, Owings Mills, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/11/84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Baltimore Co., Md.	
24. FUNERAL DIRECTOR NAME WOODLAWN MEMORIAL FH, 6411 Windsor Mill Road				25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03418			
1. DECEASED NAME (TYPE OR PRINT) <b>FRANKLIN V GENTILE</b>				2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>02 20 84 10:39A</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 07 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>(GBMC) 6701 NORTH CHARLES STREET</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECURITY GUARD</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>				13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>LUTHERVILLE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Gentile</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Note</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>WW II 220-03-0854</b>		17. INFORMANT ADDRESS <b>Alma Gentile 24 Haddington Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Circumstances of Death</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>02-20-84</b> to <b>02-20-84</b> , that (I) (we) lost <b>saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <b>[Signature]</b>				22c. DATE SIGNED <b>02-20-84</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES RICELY, MD</b>	
22e. ADDRESS <b>6701 NORTH CHARLES STREET (GBMC)</b>				22f. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 23 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, MD</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST <b>ADA</b> MIDDLE <b>T.</b> LAST <b>GENT</b> <b>ADA Thursa Gent</b>			2a. DATE OF DEATH MONTH <b>2</b> DAY <b>8</b> YEAR <b>84</b> <b>7:25 PM</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>20</b> YEAR <b>1891</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Towson - Baltimore Co. Md.</b>		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pickers gill</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Md.</b>			13b. COUNTY <b>Balto</b>		
13c. CITY OR TOWN <b>Chestnut Ridge</b>			13d. STREET ADDRESS <b>112/34 Falls Rd. 21030</b>		
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>H.</b> LAST <b>Marshall</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Margaret</b> MIDDLE <b>Mc</b> LAST <b>Maines</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-24-7520</b>		17. INFORMANT <b>Mrs. Maria Steinacker-Pickersgill</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Cardiac Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
DUE TO, OR AS A CONSEQUENCE OF <b>Cardiac Intarction</b>		<b>1 week</b>
DUE TO, OR AS A CONSEQUENCE OF <b>ASCVD.</b>		<b>10 years +</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

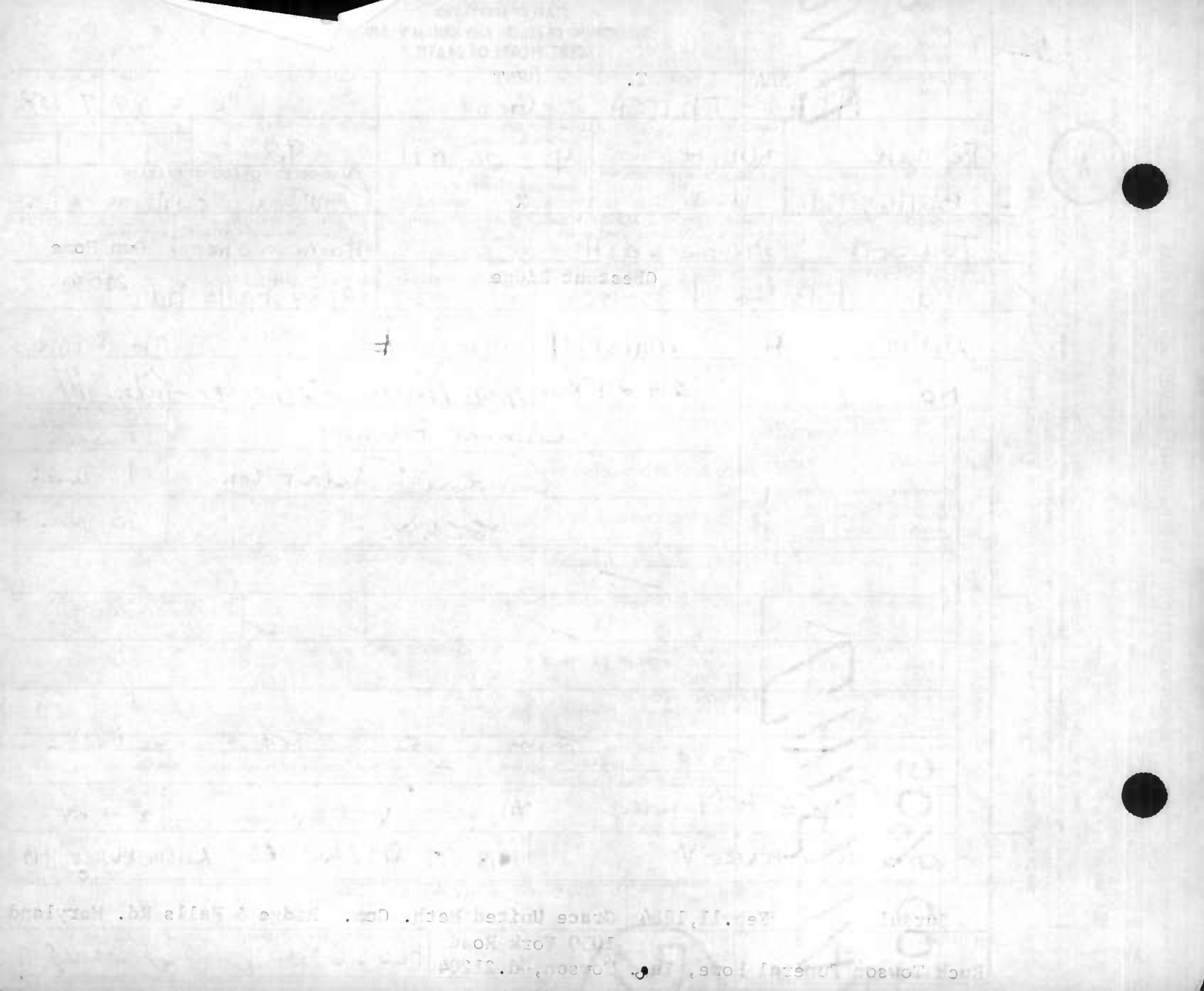
19a. DATE OF OPERATION <b>✓</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>✓</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>June</b> , 19 <b>82</b> , to <b>Feb. 8</b> , 19 <b>84</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>Feb. 8</b> , 19 <b>84</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(did)</b> (did not) view the body after death.			
22b. SIGNATURE <b>KATH A. MARLEY</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>2-9-84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KATH A. MARLEY</b>		22e. ADDRESS <b>1615, 1ST SPRING RD. LUTHERVILLE MD 21043</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 11, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grace United Meth. Cen. Ridge &amp; Falls Rd. Maryland</b>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, for bonapoppers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "I", then it allows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH P. GIBSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>February 22, 1984</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 6, 1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Dulaney Towson Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Howard Parks</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emily Cordelia</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-34-1526</b>		17. INFORMANT ADDRESS <b>James R. Gibson, 16 Fieldstone Cir. 17361</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>54 yrs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 10, 1983</b> , to <b>Feb 22, 1984</b> , that (I) (we) lost saw the deceased alive on <b>Feb 16, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Frederick J. Vollmer, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-23-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederick J. Vollmer, M.D.</b>				22e. ADDRESS <b>6100 York Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-27-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jessop Methodist</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville, Balto., Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1984</b>			
25b. REGISTRAR'S SIGNATURE <b>Jessop Methodist</b>							



Fruch Townson Funeral Home, Inc. Townson, Md. 21204

1050 York Rd.

Lessep Methodist

Cockeysville, Balto., Maryland

Burial

2-27-84

Frederick E. Voller, M.D.

6100 York Rd.

No

218-34-1526

James R. Gibson, 16 Fieldstone Cir. 17361

Joseph

Hovard

Frank

Emily

Cordelia

Maryland

Baltimore

Timonium

x

21 Relief Rd. - 21093

Townson

Elphany Townson Nursing Home

Home other

Own home

Maryland

U.S.A.

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Elk Gore County

Female

White

November 6, 1893

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NEWBETH

P.

GIBSON

February

22, 1904 12.001X



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03421

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Helen Antoinette Gigliotti</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 7 1984</b>		2b. HOUR <b>8:45<sup>A</sup></b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 1 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>8:45<sup>A</sup></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
10. CITY OR TOWN OF DEATH <b>Monkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1471 Blue Mount Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Baltimore</b>	13c. CITY OR TOWN <b>Monkton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Hornfeck</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alvina Hoff</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-34-3719</b>		17. INFORMANT ADDRESS <b>Joseph Gigliotti, 1471 Blue Mount Rd. 21111</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Monstatic colon cancer</b> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>October 1982</b> to <b>February 7 1984</b> , that (I) (we) lost saw the deceased alive on <b>January 16, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Paul Chang, M.D.</b>		DEGREE		22c. DATE SIGNED <b>2/13/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul Chang, M.D.</b>		22e. ADDRESS <b>Good Samaritan Hosp. 5601 Loch Raven Blvd., Balto., Md. 21239</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2/10/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium Balto. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Martin D. Lawson</b>		ADDRESS <b>10 W. Padonia Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, it shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

BP \_\_\_\_\_



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

031422

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret M. GILBERT			2a. DATE OF DEATH MONTH DAY YEAR February 8, 1984		2b. HOUR a <sub>m</sub> 4:05
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 17, 1917		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN 21222	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Harry Gilg			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth O'Connell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 170-01-3959		17. INFORMANT ADDRESS Everett L. Gilbert 21222 75110ld BattleGrove Rd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Renal Failure/Septic Shock</u> 4280 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

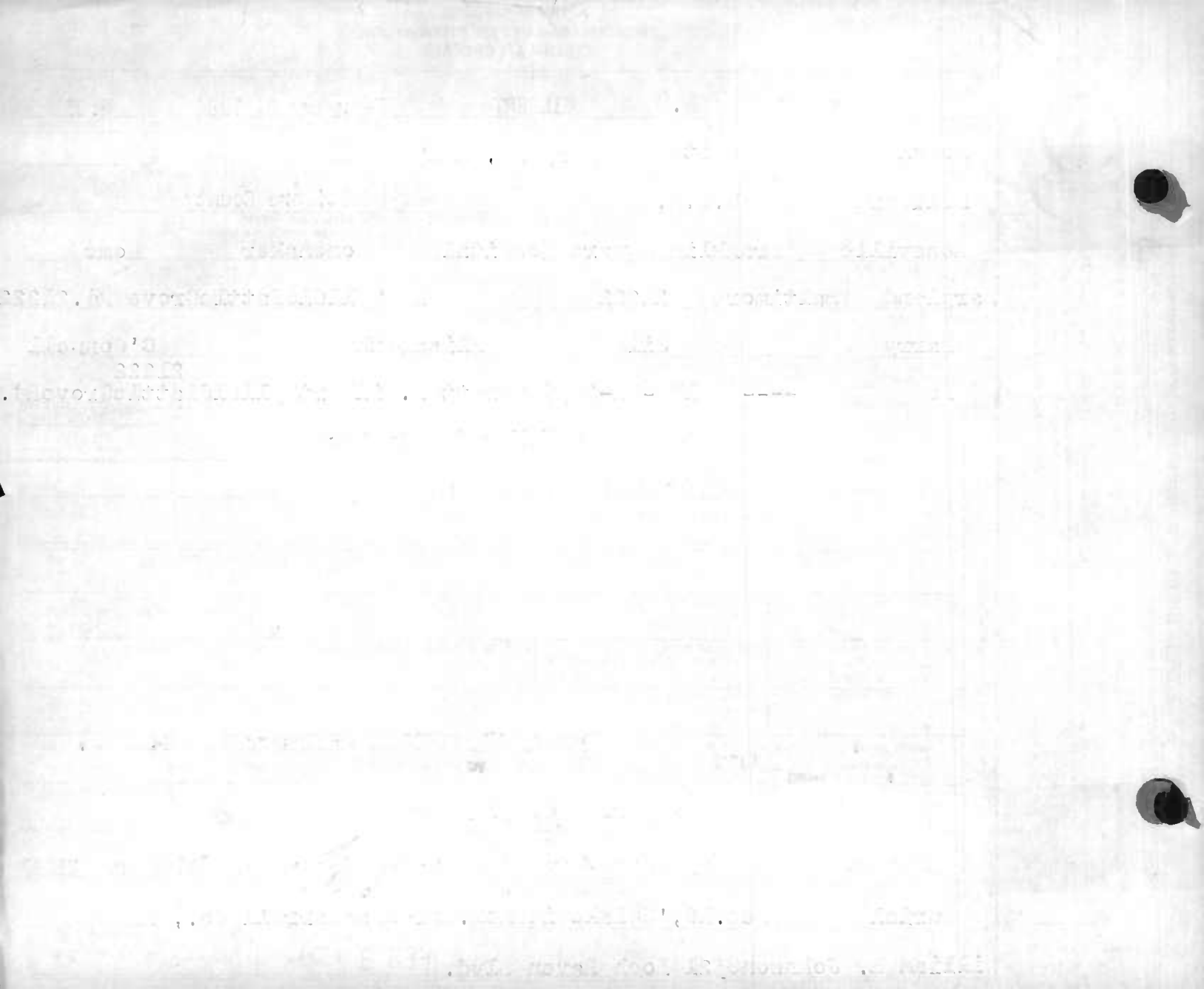
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <u>January 17</u> , 19 <u>84</u> , to <u>February 8</u> , 19 <u>84</u> , that (we) lost saw the deceased alive on <u>February 8</u> , 19 <u>84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.					
22b. SIGNATURE <u>Irene F. Ibarra, M.D.</u>		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>IRENE F. IBARRA</u>		22e. ADDRESS <u>9000 Franklin Square Dr., Baltimore, 21237</u>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Feb. 10, '84	23c. NAME OF CEMETERY OR CREMATORY Lakeview Mem. Gardens	23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Co., MD
24. FUNERAL DIRECTOR NAME William E. Johnson		25a. DATE REC'D BY REGISTRAR FEB 8 1984	
ADDRESS 8521 Loch Raven Blvd.		REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN T. GILES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-27-84</b>			2b. HOUR <b>449</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-12-29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hess Shoes</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Giles</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Fritch</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214 26 2887</b>		17. INFORMANT ADDRESS <b>Mrs Ella B Olszewski 4054 Link Ave 21236</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1629</b> IMMEDIATE CAUSE (a). <b>SMALL CELL LUNG CANCER</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-8-</b> 19 <b>84</b> , to <b>2-27</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-27</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Anthony J. Reddy</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-27-84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Anthony J. Reddy</b>		22e. ADDRESS <b>Baltimore County Gen Hospital Randallstown, MD, 21133.</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/1/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 28 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Wm Davidson Handell</b>	

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03424

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EULITH ROSLYN GILLIAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 6, 1984</b>			2b. HOUR <b>9:43a</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 26, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>64</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>202 Bloomsbury Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>202 Bloomsbury Avenue 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Watkins</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estelle Pickett</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-32-1225</b>		17. INFORMANT <b>Joseph Gillian</b>		17a. ADDRESS <b>Rd. 3 Box 189C Glen Rock, Pa. 17327</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERCALCEMIA</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>SQUAMOUS CARCINOMA OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 WEEKS</b> <b>3 MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>was</del> <b>born</b> attended the deceased from <b>NOV 64</b> , to <b>FEB 6 84</b> , that (I) <del>was</del> <b>lost</b> saw the deceased alive on <b>FEB 3 84</b> , and that in (my) <del>own</del> <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did not</del> <b>did not</b> view the body after death.									
22b. SIGNATURE <b>Paul Gormley</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/6/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL GORMLEY</b>				22e. ADDRESS <b>900 CATON AVE BALTO MD 21229</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/9/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Md.</b>			
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Regent may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP. \_\_\_\_\_





TO BE RETURNED TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201, WITHIN 24 HOURS OF DEATH.

TO BE RETURNED TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201, WITHIN 24 HOURS OF DEATH.

TO BE RETURNED TO THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201, WITHIN 24 HOURS OF DEATH.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR Item 4 phone 2-24-84					REG. NO. 03425				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST					MONTH DAY YEAR				
ALICE H GOBSTER					2-6-84				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
F		Caucasian		6-27-02		81		123 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 1 YEAR	
PA.		U.S.A.				BALTO. CO.		MONTHS DAYS HOURS MIN.	
11. CITY OR TOWN OF DEATH		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14. KIND OF BUSINESS OR INDUSTRY			
RANDALLSTOWN		BALTO. CO. GEN. Hosp.		HOUSEWIFE					
15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15b. CITY OR TOWN		15c. INSIDE CITY LIMITS?		16. STREET ADDRESS		21207	
MD.		BALTO.		RANDALLSTOWN		2102 N. ROLLING RD.			
17. FATHER'S NAME		18. MOTHER'S MAIDEN NAME		19. INFORMANT		20. ADDRESS			
FRANK P. RYAN		ANNA ROSE		MARY DINKLOCKER		SAME		21207	
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		21b. SOCIAL SECURITY NO.		22. INFORMANT		23. ADDRESS			
NO		191-14-7888		MARY DINKLOCKER		SAME		21207	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE 4140 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10. POSS. CEREBRO VASCULAR ACCIDENT.									
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26a. AUTOPSY?		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
N/A				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		28a. LOCATION CITY OR TOWN COUNTY STATE			
27a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		27b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		27c. LOCATION CITY OR TOWN COUNTY STATE		28a. LOCATION CITY OR TOWN COUNTY STATE			
28a. I certify that (I) (this hospital) attended the deceased on 1-23-84, to 2-6-84, that (I) (we) lost saw the deceased alive on 1-23-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.		28b. SIGNATURE		28c. DATE SIGNED		29a. PHYSICIAN NAME (TYPE OR PRINT)		29b. ADDRESS	
		MD		2-6-84		VONDYAR V. REDDY MD		BALTO. COUNTY GEN HOSPITAL RANDALLSTOWN, MD, 21133.	
30a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		30b. DATE		30c. NAME OF CEMETERY OR CREMATORY		30d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		2-9-84		ST. STEPHENS CEM.		SHEMANDOTH, PA.			
31. FUNERAL DIRECTOR NAME		32. BALTIMORE REGISTRAR		33. BALTIMORE REGISTRAR		34. BALTIMORE REGISTRAR			
CAP. TEL. FUN. SER. FALLS CHURCH VA.		FEB 8 1984		FEB 8 1984		FEB 8 1984			

ALICE F H  
 5-5-81 81 5-5-81  
 5-5-81 5-5-81

Colony of Ants

L.A.  
 L.A. General Account

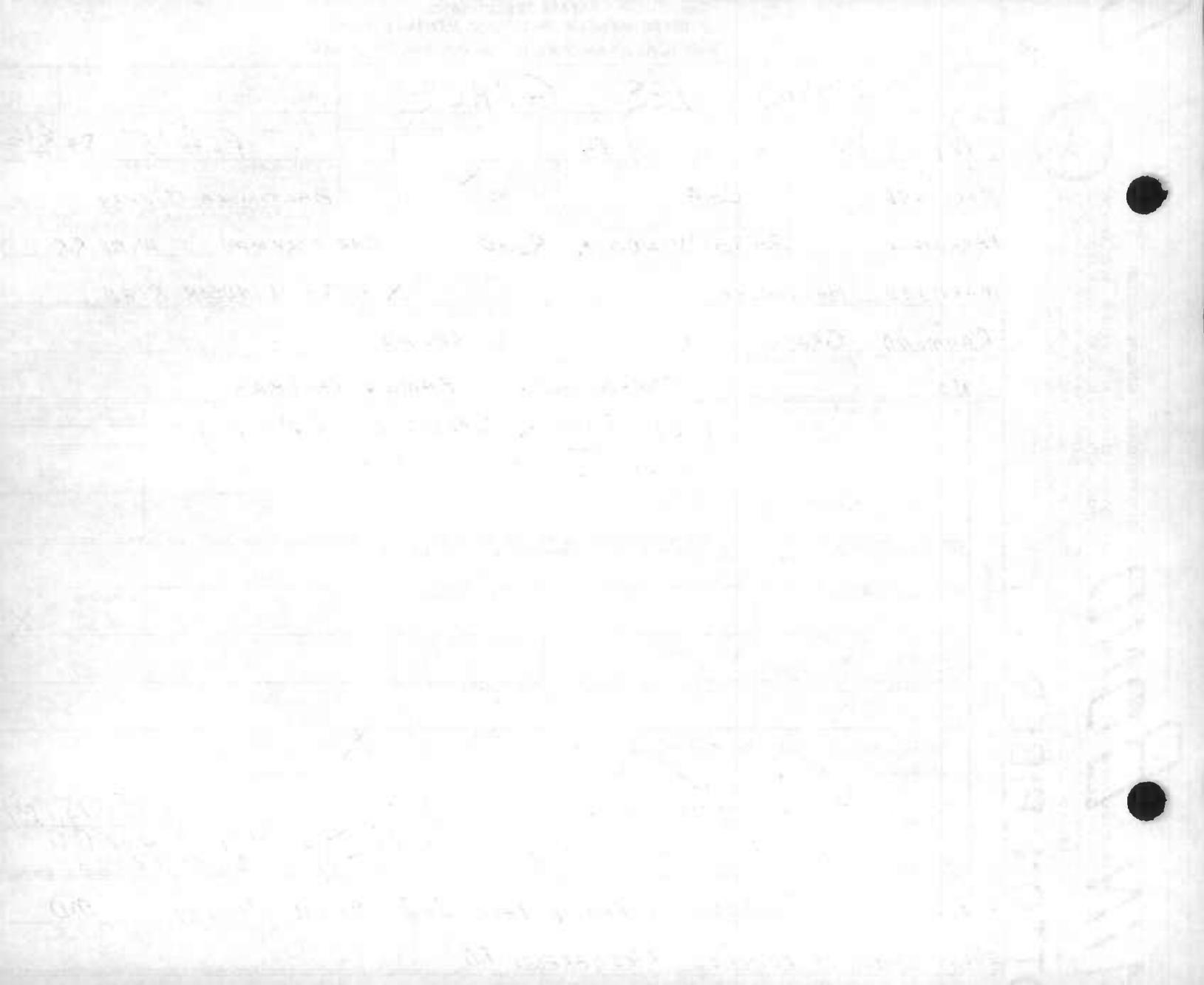
5-5-81 5-5-81 5-5-81  
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 5-5-81 5-5-81 5-5-81

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03426	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RAYMOND LEE GRACE</b>										20. DATE KNOWN OF DEATH MONTH DAY YEAR <b>FEB 15 1984</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 10 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>84</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	21. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>FEB 15 1984</b>		26. HOUR <b>6:16</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>				
10. CITY OR TOWN OF DEATH <b>PARKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2523 WINDSOR ROAD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CAR FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>W. MD. R.R.</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2523 WINDSOR ROAD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>RAYMOND GRACE</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LEONA</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>705-10-6009</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF <b>ARTERIOSCLEROTIC CARDIO - VASCULAR DISEASE</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Paul F. Guerin</b>				M.D. TITLE (SPECIFY) <b>DEPUTY</b>				DATE SIGNED <b>FEB 15, 1984</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL F. GUERIN</b>				ADDRESS <b>1311 WESTERN RUN RD COCKEYVILLE MD 2103D</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>2/17/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. COUNTY MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD RD.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03427

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FLORENCE</b> <b>GREGORY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 16 84</b>			2b. HOUR <b>4 05</b> M.			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 31 11</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balt. County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BCHH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Balt.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8206 Arrowhead Rd.</b> 21208	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL</b> <b>SCHWARTZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BESSIE</b> <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>214-01-1797</b>		17. INFORMANT <b>MR. MICHAEL GREGORY</b> <b>8206 ARROWHEAD RD. BALTO., MD 21208</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**1830**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

**Lung Cancer**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2-13-84</b> to <b>2-16-84</b> , that (I) (we) last saw the deceased alive on <b>2-16-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Soonchul Hong</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>2-16-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOONCHUL HONG</b>				22e. ADDRESS <b>Baltimore County General Hosp'tal</b>			

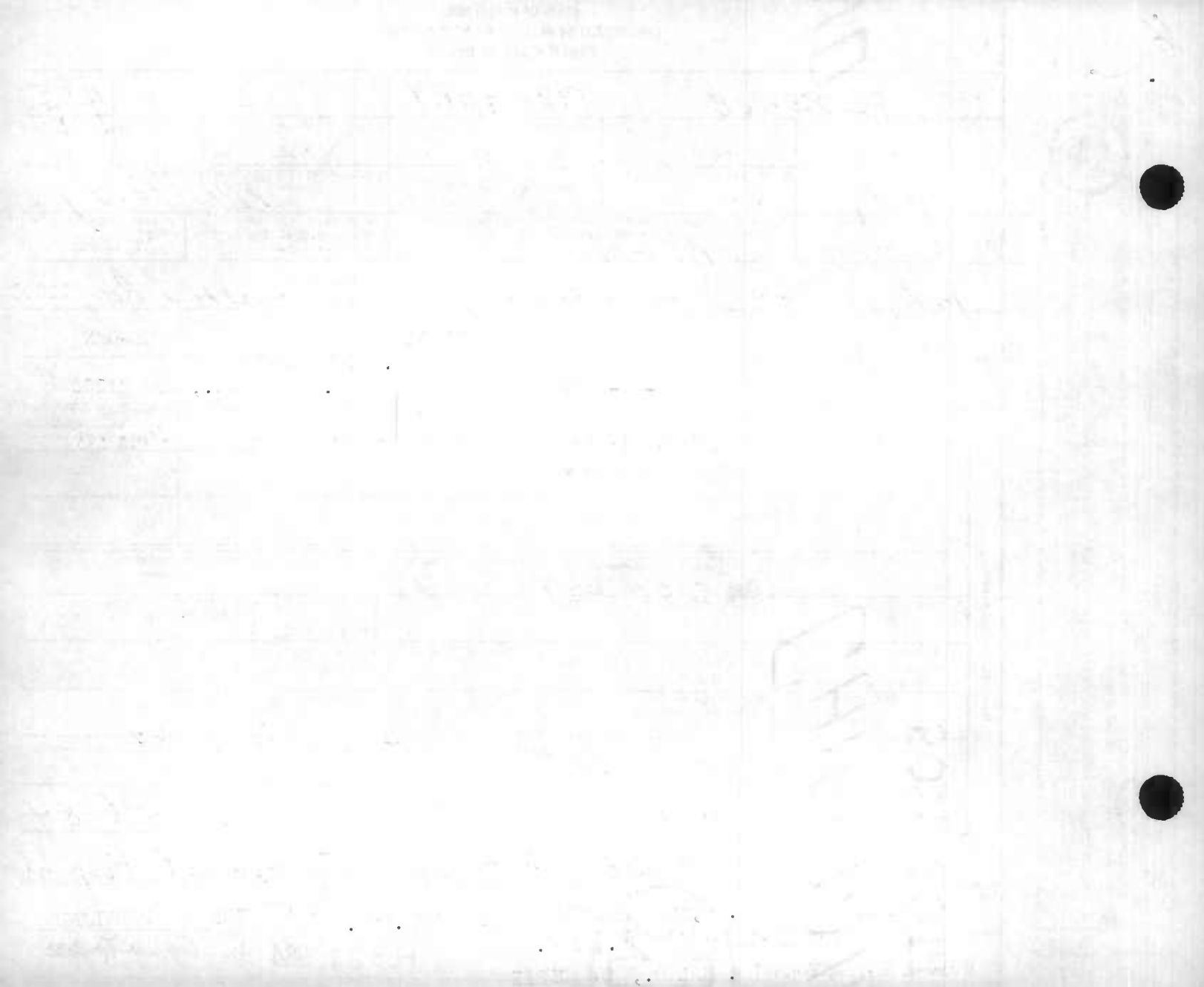
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>FEB. 19, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW ORTHODOX MEM. SOC.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examination must be without delay.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03428

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph E. Grimm</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 29 84</b>		2b. HOUR <b>7:00 PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 11 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Dundalk</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3524 Dunhaven Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Martin-Marietta</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Worker</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Dundalk</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael C. Grimm</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Loris</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-09-4830</b>		17. INFORMANT ADDRESS <b>Elizabeth A. Grimm Same as 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC RENAL CELL CARCINOMA</b> <b>1890</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/14</b> 19 <b>82</b> , to <b>2/16</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>2/16</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael R. Camp, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>3/1/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL R. CAMP, M.D.</b>		22e. ADDRESS <b>9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/3/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>MAR 6 1984</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP \_\_\_\_\_

FILED

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000

100-100000-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOHN J. GRZYMALA			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 6, 1984		2b. HOUR 11 P. M.	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB. 8, 1909	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3010 MORELAND AVE. 21234		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL	
13a. STATE MD.	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3010 MORELAND AVE. 21234		
14. FATHER'S NAME FIRST MIDDLE LAST FELIX GRZYMALA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA TUREK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-09-0030		17. INFORMANT ADDRESS BERTHA GRZYMALA 3010 MORELAND AVE. 21234		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 METASTATIC LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Nathan M. Rosenblum		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8 Feb 84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NATHAN M. ROSENBLUM M.D.		22e. ADDRESS 7600 OSLER DR.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE FEB. 10, 1984	23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.		
24. FUNERAL DIRECTOR J. Miller - 7527 Harford Rd.		25a. DATE REC'D. BY REGISTRAR FEB 9 1984		25b. REGISTRAR'S SIGNATURE John J. Miller		



2025 COM

CHERRY

114 114

03430

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Carlton		MIDDLE Adolph		LAST Guenther		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR 12:45 P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 20 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Presbyterian Home of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive		12b. KIND OF BUSINESS OR INDUSTRY Transport. Co.					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 400 Georgia Court,		Towson, Md. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick J. Guenther		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth C.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-1889		17. INFORMANT C. Warren Green		ADDRESS 23 Puddingstone Drive Boonton, N. J. 07005					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLECTIC CARDIOVASCULAR DISEASE</u> 4rs (c) <u>GENERALIZED ARTERIOSCLECTOSIS</u> 4rs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH - MID -									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Gen. L. ty</u>											
19a. DATE OF OPERATION 7		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6-2-1969</u> to <u>2-6-1984</u> , that (I) <del>was</del> lost saw the deceased alive on <u>2-1-1984</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did not) view the body after death.											
22b. SIGNATURE <u>Sidney J. Venable, Jr.</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-7-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sidney J. Venable, Jr., M.D.		22e. ADDRESS 7215 York Rd. Baltimore, Md. 21212									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 9, 1984		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland 21229					
24. FUNERAL DIRECTOR NAME G. Truman Schwab, 5151 Balto. Natl. Pike, Balto. Md. 21229		355B 15 1984		25a. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>							

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. If a delay may be required, the physician must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must file the notification.

APR 1 1964

RECEIVED

APR 1 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as true, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
Theresa		FIRST MIDDLE LAST GUNTER		February 7, 1984	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		8 12 23	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
Maryland		USA		60	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rossville		Franklin Square Hospital		housewife	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		4041 Walter Avenue 21236	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		17. INFORMANT	
Charles Gehring		Theresa Happel		4041 Walter Ave.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		ADDRESS	
no		193-12-		Wm. R. Gunter, Sr. Balto., Md. 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest					
4960 DUE TO, OR AS A CONSEQUENCE OF					
Chronic Obstructive Pulmonary Disease					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that X (this hospital) attended the deceased from February 7, 1984, to February 7, 1984, that X (we) last saw the deceased alive on February 7, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Michael Heller				2/7/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Michael Heller, M.D.				9000 Franklin Square Drive 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-10-84		Meadowridge Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Lassahn Funeral Home		FEB 14 1984		Julia Davidson-Randall	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03432

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mr. Philip S. Hahn</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 24 1984</b>			7b. HOUR M <b>M</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 2 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		7a. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>				
10. CITY OR TOWN OF DEATH <b>Woodlawn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2148 Lorraine Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Test Gauges</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Glen L. Martin</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3918 Noyes Cr. Apt. 104 21133</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Melvin Sheridan Hahn</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilhelmina Augusta Kuehne</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>705-05-0862 A</b>		17. INFORMATION <b>Mrs. L. Virginia Hahn</b>				ADDRESS <b>3918 Noyes Circle 104 Randallstown Maryland 21133</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1629 Mesothelioma of Lungs</b> IMMEDIATE CAUSE (a) <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mths</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>G.I. Bleeding, Hypertension, Chronic renal failure</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <b>11-01-1983</b> to <b>12-16-1983</b> , that (I) (we) lost saw the deceased alive on <b>12-16-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Tahoora Kawaja</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>2/24/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Tahoora Kawaja</b>				22e. ADDRESS <b>8204 Liberty Road 21207</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>02-27-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Maryland</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Lia Davidson-Randall</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



February 20 1964

Mr. Philip S. Hahn

April 2 1964

Cambridge

Mass

Belmont County

N.H.A.

Newport

1964 Belmont County

Belmont

West Virginia

John L. Martin

Belmont County

West Virginia

Belmont

2173

2173 Belmont Co. W. Va.

Belmont County West Virginia

Belmont County West Virginia

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John L. Martin

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Belmont County West Virginia

Belmont County West Virginia

West Virginia Belmont County

Belmont County West Virginia

Belmont County West Virginia

Belmont County West Virginia

Belmont County West Virginia

1964 Belmont County West Virginia



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Henry HAJEK			2a. DATE OF DEATH MONTH DAY YEAR February 20, 1984		2b. HOUR 12:08pm
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1905	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker	12b. KIND OF BUSINESS OR INDUSTRY Univ. of MD. Hospital	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Hajek			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adele Zeleny		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --	17. INFORMANT ADDRESS Perry Hall, Md. 21128 Vilma McConville, 9825 Forge Park Rd.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD + mitral valve disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>several yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Polymyositis rheumatica</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 3, 1984</u> to <u>Feb 20, 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <u>Charles M. Kerr</u>		DEGREE MD - ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-22-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Kerr, M.D.		22e. ADDRESS 6801 Belair Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2/24/84	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto, Md.	
24. FUNERAL DIRECTOR NAME SCHIMUNEK FUNERAL HOME, 9705 Belair Rd, 21236		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 1984		25c. REGISTRAR'S SIGNATURE John Davidson	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
ARTHUR A. HAMPSHIRE		February 7, 1984		3:16 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
MALE	WHITE	MARCH 13, 1931	52 YRS.	Baltimore County MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore	U.S.A.		Baltimore County MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Co.
Towson	Greater Baltimore Medical Center		MANG-T		S.L. STUBBINS
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
		MARYLAND	Baltimore	Parkville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE	
ARTHUR A. HAMPSHIRE		Ellen C. FRIED		8703 ROPER ROAD 21234	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
no	212 284897	Family Records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction					
4100 DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/02, 1984, to 2/07, 1984, that (I) (we) last saw the deceased alive on 2/07, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
RLS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		2/08/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Ronald L. Sirota, M.D.		6701 N. Charles St. Baltimore MD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
CREMATION	FEB. 10, 1984	Green Mount Cem.		Baltimore Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR	
EVANS CHAPEL OF MEMORIES		8300 HARFORD ROAD		FEB 14 1984	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 4 3 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) VERA E. HAMPTON			2a. DATE OF DEATH MONTH DAY YEAR 02 18 1984		2b. HOUR 8:10 A M
3. SEX FEMALE	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 03 10 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CO. MD.	
10. CITY OR TOWN OF DEATH BALTO	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) St. Joseph's Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical	12b. KIND OF BUSINESS OR INDUSTRY Dept. Store
13a. STATE MD			13b. COUNTY BALTO	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Burnham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Seymour		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-36-1514		17. INFORMANT ADDRESS Wm. Kenney (friend) same address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC FAILURE

4289  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE ERLANDO ROMERO		DEGREE		22c. DATE SIGNED 2/18/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ERLANDO ROMERO		22e. ADDRESS ST. JOSEPH HOSPITAL		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE 2/20/84	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park	23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.
24. FUNERAL DIRECTOR NAME Schimuenk Funeral Home, Inc. 3331 Brehms Lane, Balto. 21213		25a. DATE REC'D. BY REGISTRAR FEB 21 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1000



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03430

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PEGGY M. HANCOCK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 5, 84</b>			2b. HOUR <b>5:15 A</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 14 29</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Meryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Rendallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nursing Tech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Health Care</b>		
13a. STATE <b>Meryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Cetonsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1204 Canberwell Rd. 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Inez Cox</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-28-2372</b>		17. INFORMANT <b>Kenneth L. Hancock</b>				ADDRESS <b>Same as 13e</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Carcinoma of</b> <b>1749</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>the breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 28, 1984</b> to <b>Feb. 5, 1984</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Ghassem Pourmotarbed</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-5-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GHASSEM POURMOTARBED</b>				22e. ADDRESS <b>Balto. Co. General Hospital</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-7-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Leroy M. &amp; Russell C. Witzke</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 6 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Handwritten notes and stamps, including a circular stamp on the right side. The text is mostly illegible due to fading and bleed-through from the reverse side of the page.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03437

REG. NO.

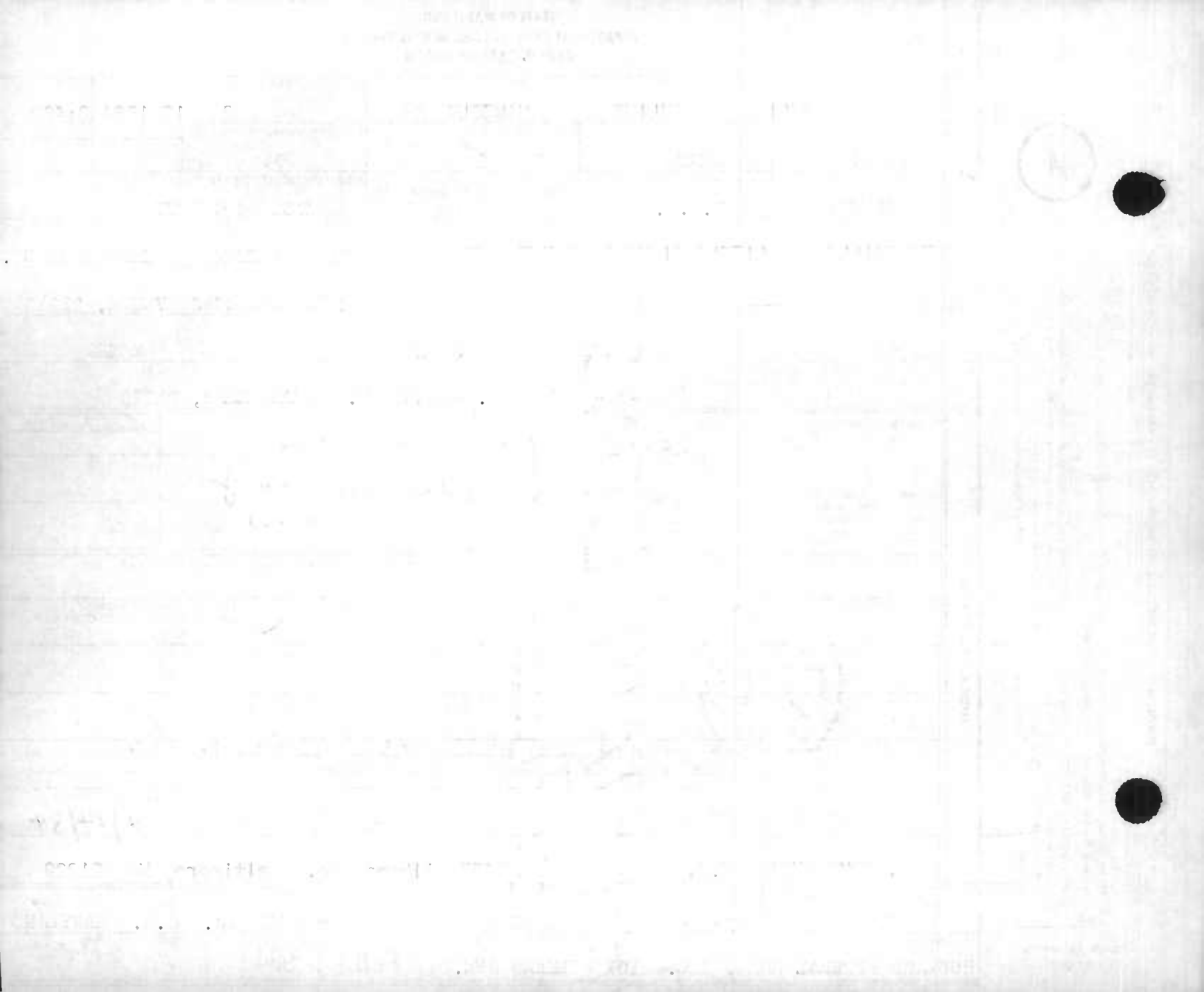
1. DECEASED NAME (TYPE OR PRINT) JULIA PAULINE HANZELY			2a. DATE OF DEATH MONTH DAY YEAR 2 12 1984			2b. HOUR 8:40P M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07 10 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LITTLE SISTERS OF THE POOR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNDERWRITER		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE CO.	
13a. STATE MARYLAND		13b. CITY ---		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3528 CARDENAS AVENUE, 21213			
14. FATHER'S NAME FIRST MIDDLE LAST MARTIN HANZELY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA BEIER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-07-8811		17. INFORMANT ADDRESS SR. DOREEN ST. MARTIN HOME, 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio respiratory failure 1539 DUE TO, OR AS A CONSEQUENCE OF (b) metastatic adenocarcinoma of colon DUE TO, OR AS A CONSEQUENCE OF (c) colon									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:40 P.M. 2 11 1984			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 19 83, to Feb 9 1984, that (I) (we) last saw the deceased alive on 2/9/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE N. RAVENDHRAN, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 3455 Wilkens Ave., Baltimore, MD 21229						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 02-15-84		23c. NAME OF CEMETERY OR CREMATORY HOLY CROSS		23d. LOCATION CITY OR TOWN COUNTY STATE BROOKLYN PK. A.A. MARYLAND		
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.			ADDRESS 4107 WILKENS AVE.			25a. DATE REC'D. BY REGISTRAR FEB 15 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner and the method of autopsy should be noted on the back of this certificate.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 4 3 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Lionel Wilber HARE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 23, 1984</b>		2b. HOUR <b>12:40am</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Sept. 22, 1917</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b>	7. UNDER 1 YEAR MONTHS DAYS YRS.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	9. CITIZEN OF WHAT COUNTRY? <b>USA</b>	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
12. CITY OR TOWN OF DEATH <b>Rossville 21237</b>	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Sq. Hospital</b>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Plumber</b>	15. KIND OF BUSINESS OR INDUSTRY <b>Home Repair</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Essex 21221</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>1629 Dartford Rd. Apt "A" 21221</b>	
14. FATHER'S NAME <b>Joseph Andrew Hare</b>		15. MOTHER'S MAIDEN NAME <b>Alberta Sweetmon</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>213 18 3484</b>	17. INFORMANT ADDRESS <b>Frances Hare, Wife Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5860 Pulmonary Edema</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>February 21, 19 84</b> to <b>February 23, 19 84</b> , that <input checked="" type="checkbox"/> (we) lost <b>February 23, 19 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Darius Russin M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>2/23/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Darius Russin, M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE <b>2/25/84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>		
24. FUNERAL DIRECTOR <b>Bozdzinski</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE CLAIRE HARPER				2a. DATE OF DEATH MONTH DAY YEAR February 26, 1984			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1203 Robin Hood Circle		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Gaskins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Duvall		13e. STREET ADDRESS 1203 Robin Hood Circle 21204			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-10-3352		17. INFORMANT ADDRESS Mr. Alan J. Harper same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, primary site</u> 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Uncertain; ? breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> 19 <u>61</u> , to <u>Feb 27</u> 19 <u>84</u> , that (I) <u>lost</u> saw the deceased alive on <u>Feb 20</u> 19 <u>84</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, <u>if</u> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Worth B. Daniels, Jr.</u> DEGREE <u>M.D.</u>				22c. DATE SIGNED 2/27/84		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Worth B. Daniels, Jr.				22f. ADDRESS 11 E. Chase Street, Suite 4B			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/29/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Ruck Towson Funeral Home, Inc. 1050 York Rd.				25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Health Department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed.

1- FOR Item 13e 3-6-84 cn  
STATE REGISTRAR  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Harris B.G.</b>			7a. DATE OF DEATH MONTH <b>2</b> DAY <b>12</b> YEAR <b>1984</b>		7b. HOUR <b>5:45 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>11</b> YEAR <b>1984</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>1 day</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>None</b>	
13a. USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>None</b> MIDDLE <b>None</b> LAST <b>None</b>		15. MOTHER'S MAIDEN NAME FIRST <b>None</b> MIDDLE <b>None</b> LAST <b>None</b>		13e. STREET ADDRESS <b>2402 Pickering Dr. 21234</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiorespiratory collapse**

**7651**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Prematurity**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

**1 hour Birth.**PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **None**

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR <b>11</b> A.M. MONTH <b>2</b> DAY <b>12</b> YEAR <b>1984</b> P.M.	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4:12 PM</b> 19 <b>84</b> to <b>2:12 PM</b> 19 <b>84</b> , that (I) (we) lost saw the deceased have on <b>above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)</b>			
22b. SIGNATURE <b>Daniel E. Wallach, MD</b>	DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/12/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel E. Wallach, MD</b>	22e. ADDRESS <b>St Joseph Hospital</b>		

23a. BURIAL, CREMATION, REMOVAL (REMARKS) <b>Removal Burial</b>	23b. DATE <b>2-12-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>St Joseph hospital</b>		25a. DATE REC'D. BY REGISTRAR <b>2/12/84</b>	25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rodde</b>

Handwritten notes at the top of the page, including a circled '1' and various illegible scribbles.

Main body of handwritten notes, consisting of several lines of illegible cursive script.

St Joseph Hospital  
Towson, MD 21204  
Date: 10/1/78  
Hospital: St Joseph



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03441

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MILTON JULIAN HAUGE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 9, 1984</b>			2b. HOUR <b>9:00a</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 17, 1927</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>56</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Towson 21204</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>#1 Edgeclift Road 21204</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Communication</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21204</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>#1 Edgeclift Rd. 21204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Selmer Hauge</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Petra Bosaaen</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>W.W. II</b>		17. INFORMANT <b>Bonnie L. Hauge</b>		ADDRESS <b>#1 Edgeclift Rd. 21204</b>				

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**VENTRICULAR FIBRILLATION****4100**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **ACUTE MYOCARDIAL INFARCT**

DUE TO, OR AS A CONSEQUENCE OF

(c) **CORONARY ARTERY DISEASE**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

**ARTERIAL HYPERTENSION**

19a. DATE OF OPERATION

**NA**

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

**NA**

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. **NA** 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

**NA**

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)**NA**

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

**NA**22a. I certify that (I) (this hospital) attended the deceased from **June 1978** to **February 1984**, that (I) (we) last saw the deceased alive on **Jan 1984**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

**M.D.**ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

**2-10-84**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**Adolfo L. Lopez, M.D.**

22e. ADDRESS

**Ruxton Towers Suite #109 828-1273**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

**Burial**

23b. DATE

**Feb. 14, 1984**

23c. NAME OF CEMETERY OR CREMATORY

**Garrison Forrest Veterans Baltimore Co., MD**

23d. LOCATION

**Baltimore Co., MD**

24. FUNERAL DIRECTOR

NAME

**William E. Johnson**

ADDRESS

**8521 Loch Raven Blvd.**

25a. DATE REC'D. BY REGISTRAR

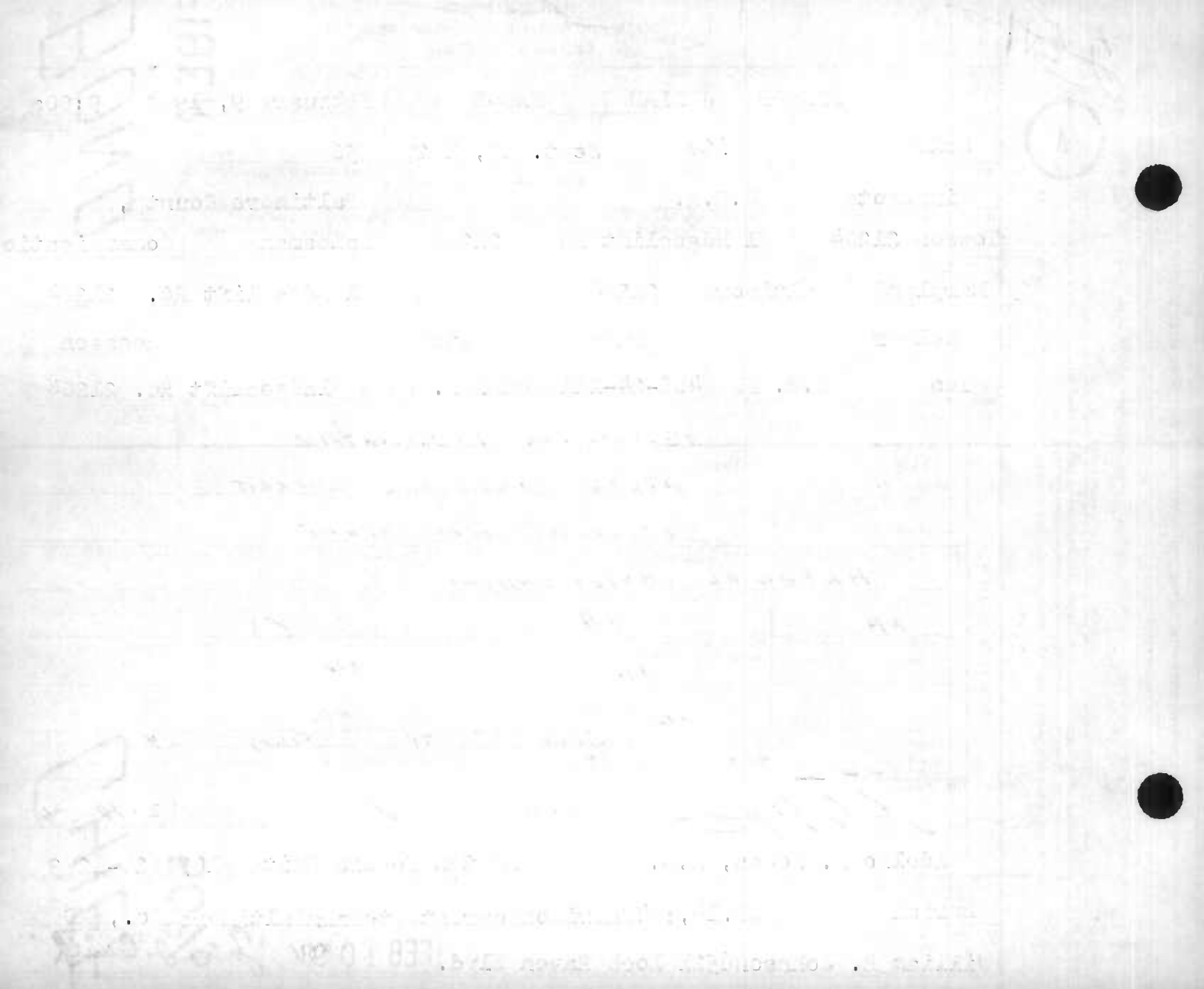
**FEB 10 1984**

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



BP

DHMM - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

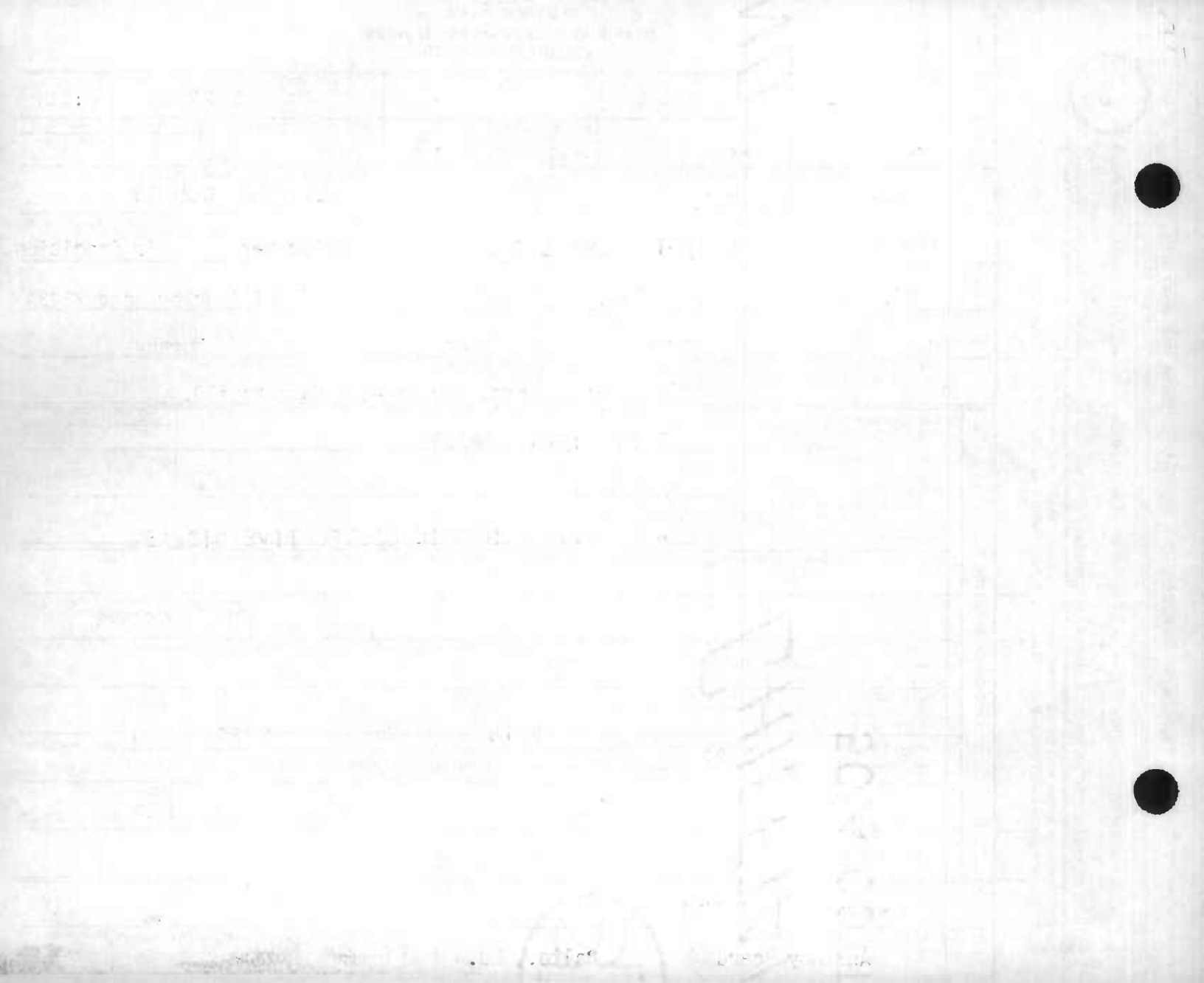
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROLAND G. HAYES</b>			2a. DATE OF DEATH MONTH <b>2</b> DAY <b>22</b> YEAR <b>84</b>			2b. HOUR <b>4:30 PM</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>1</b> YEAR <b>15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 74 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>London</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N CHARLES ST</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Air Condition.</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3123 Willoughby Road 21234</b>			
14. FATHER'S NAME FIRST <b>Harry</b> MIDDLE <b></b> LAST <b>Hayes</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b> MIDDLE <b></b> LAST <b>Murphy</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>212-36-0733</b>		17. INFORMANT ADDRESS <b>Mrs. Amy Hages - Same as #13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>4860</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>PNEUMONIA</b> (c) <b>EXACERBATING CHRONIC OBSTRUCTIVE DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> 19 <b>84</b> to <b>2/22</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/22</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Mary Ann Moore MD</b>						DEGREE		22c. DATE SIGNED <b>2-22-84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR MARY ANN MOORE</b>						22e. ADDRESS <b>GBMC</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>2/23/84</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b> ADDRESS <b>Balto., Md.</b>						25a. DATE RECEIVED BY REGISTRAR <b>FEB 28 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 should be filled in.

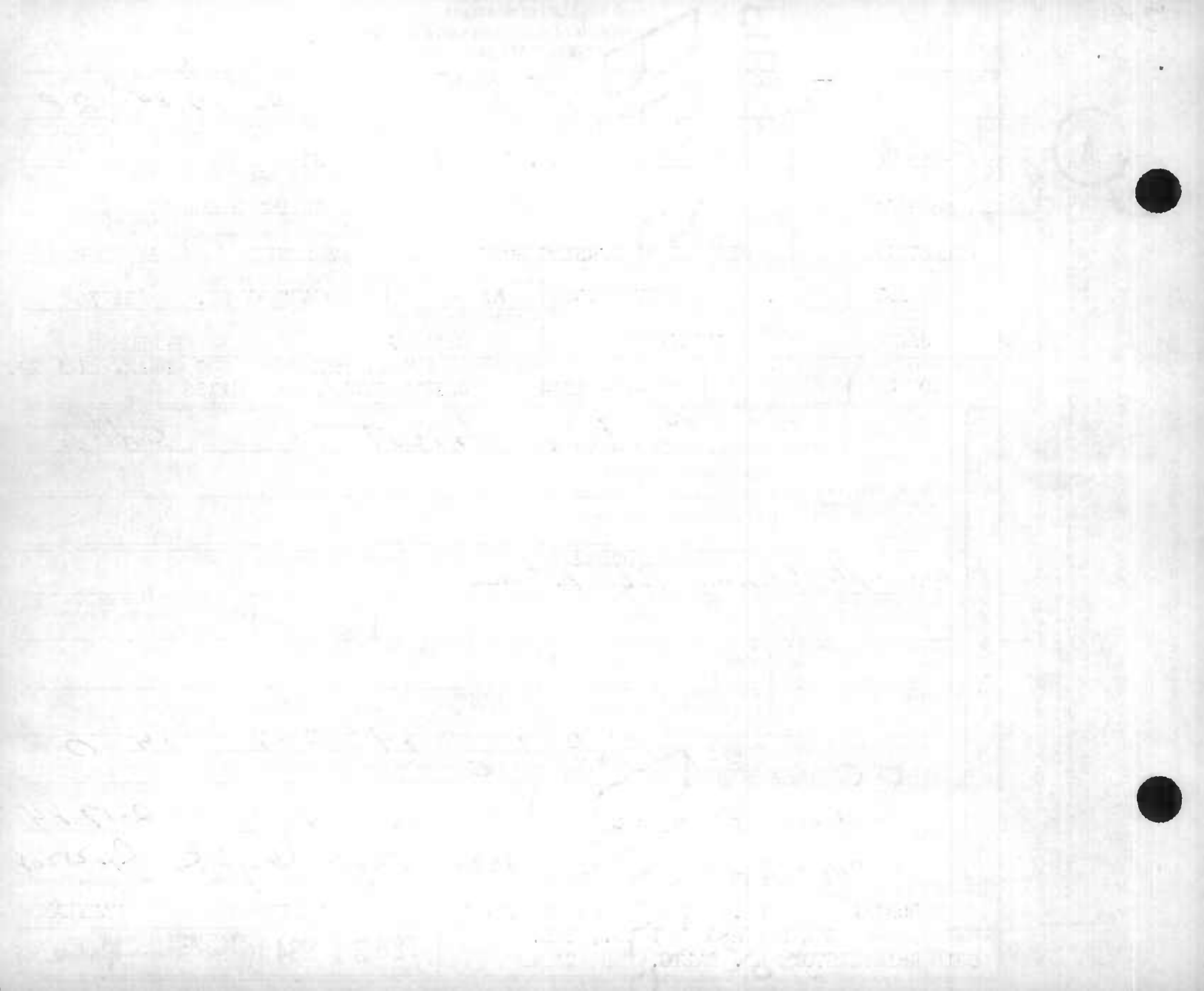
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Hechmer</i> <i>LAST</i> <i>FIRST</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>2 17 84</i>		2b. HOUR <i>2 P.</i>	
3. SEX <i>Female</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>MAR. 4, 1901</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <i>PIKESVILLE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>PIKESVILLE NURSING HOME</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE COUNTY</i> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>PIKESVILLE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTO.</i>		13c. STREET ADDRESS / ZIP CODE <i>3 SUGARBURY CT. #21236</i>	
14. FATHER'S NAME <i>JACOB</i> <i>FIRST</i> <i>MIDDLE</i> <i>LAST</i> <i>MAROVITCH</i>		15. MOTHER'S MAIDEN NAME <i>REBECCA</i> <i>FIRST</i> <i>MIDDLE</i> <i>LAST</i> <i>FREEDMAN</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	
16b. SOCIAL SECURITY NO. <i>212-16-3254M</i>		17. INFORMANT <i>EDWARD HECHMER</i> <i>REISTERSTOWN, MD</i>		17b. ADDRESS <i>302 CHERRY HILL RD. 21136</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4275</i> IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Multiple Chronic Degenerations</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>2-1 19 84</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>2-1 19 84</i> to <i>2-17 19 84</i> , that (I) (we) lost saw the deceased alive on <i>2-1 19 84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did) (did not) view the body after death.		22b. SIGNATURE <i>Harold B. Bob</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED <i>2-17-84</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Harold B. Bob</i>		22e. ADDRESS <i>7220 Park Heights Ave 21208</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>FEB. 19, 1984</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SHAAREI TFILOH</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MARYLAND</i>		24. FUNERAL DIRECTOR <i>SOL LEVINSON &amp; BROS., INC.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 21 1984</i>	
25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>		25c. ADDRESS <i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For every day retained by the hospital or attending physician.

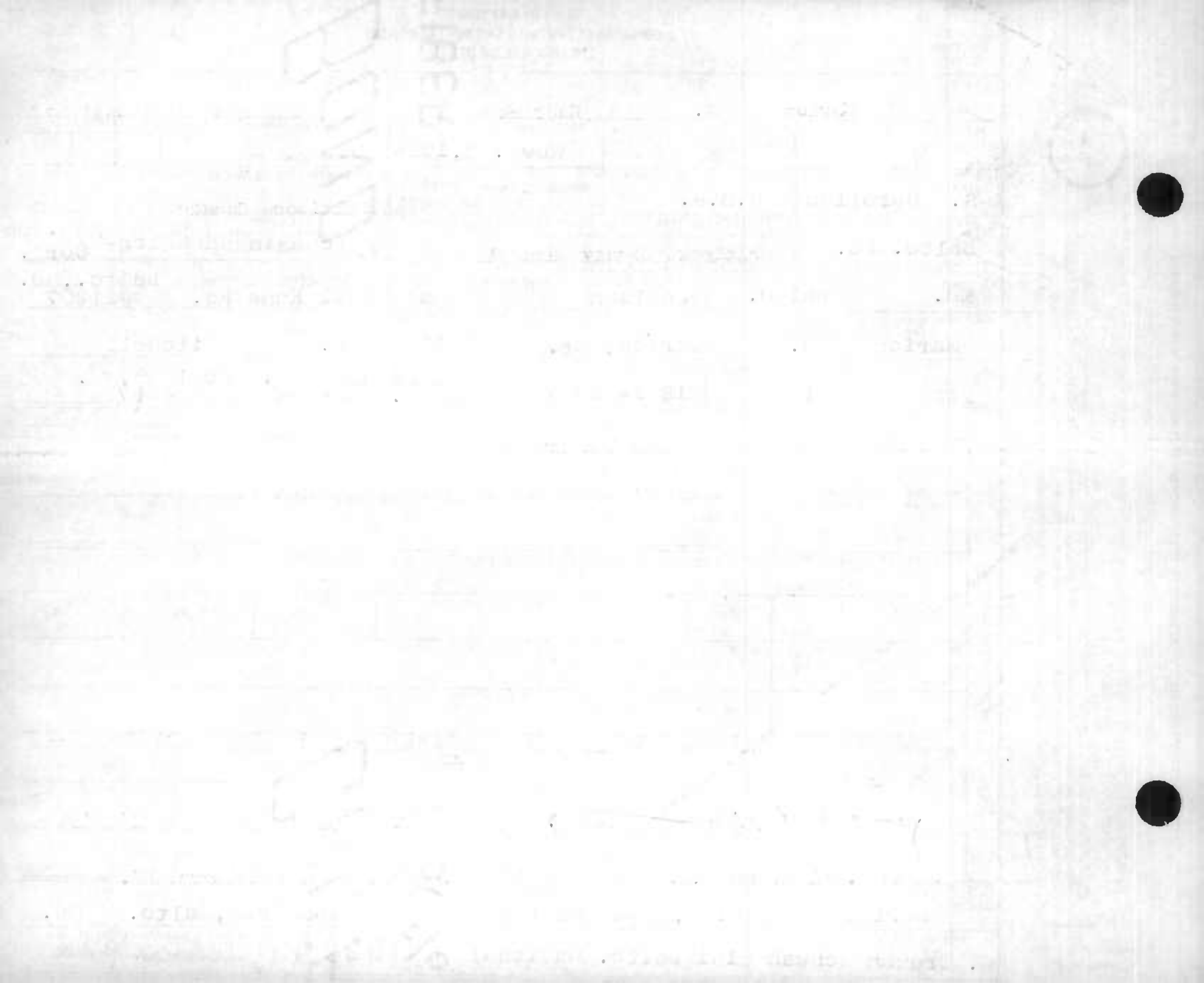
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be furnished for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, however injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 03444				
1. FOR STATE REGISTRAR					1. DECEASED NAME				
FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				
Marion M. Hedrick					2 24 1984 11:07 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
M		W		MONTH DAY YEAR Nov 9, 1924		59		24 1984 11:07 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
S. Carolina		U.S.A.				Baltimore County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Balto. Co.		Baltimore County General				Purchasing Manager		Gen. Ins Corp.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					13e. STREET ADDRESS / ZIP CODE				
Md. Balto. Woodlawn					2811 Rona Rd. #21207				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Marion M. Hedrick, Sr.					Emily A. Mitchell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
yes II					218 14 9387		2811 Rona Rd. Woodlawn, Md. Norine L. Hedrick #21207		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac arrest									
4292 DUE TO, OR AS A CONSEQUENCE OF									
(b) Arteriosclerotic cardiovascular disease									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
Diabetes, Emphysema									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
					P.M. 19				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7, 19 81, to 2, 19 84, that (I) (we) lost									
saw the deceased alive on 2/22, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
James H. Biddison, M.D.								2/24/84	
22d. PHYSICIAN'S NAME (TYPE OFFICE)					22e. ADDRESS				
					6301 N. Charles St. Baltimore, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			Feb. 27, 1984		Woodlawn			Balto. Md.	
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
G. Truman Schwab 5151 Balto. National					FEB 29 1984 John Davidson-Randall				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03445

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Louis S Heim			2a. DATE OF DEATH MONTH DAY YEAR February 15, 1984			2b. HOUR M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 4 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto Co MD				
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST Joseph Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Retail Seafood Market		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Milford		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3609 Buckingham Rd. 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Louis J. Heim				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST E. Roberta Unknown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Lutherville, ADDRESS MD 21093 Mrs. Stanley Speakman 107 Belmore Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Arteriosclerotic Vascular Disease</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Barry Josephs						22c. ADDRESS 7620 York Rd. Towson Md.		22d. DATE SIGNED 2/15/84		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY JOSEPHS, M.D.						22f. ADDRESS 7620 York Rd. Towson Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/18/84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD 21204			
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, Inc. NAME ADDRESS 8728 Liberty Rd. Randallstown, MD 21133						25a. DATE REC'D. BY REGISTRAR FEB 17 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MARY P HELFRICH</b>				2a. DATE OF DEATH MONTH <b>02</b> DAY <b>28</b> YEAR <b>84</b>		2b. HOUR <b>M</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH <b>10</b> DAY <b>28</b> YEAR <b>1887</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10 CITY OR TOWN OF DEATH <b>RANDALSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Seamstress</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Balto. City</b> 13c. CITY OR TOWN <b>BALTO</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3808 Gwynn Oak Avenue 21207</b>	
14 FATHER'S NAME FIRST <b>Ira</b> MIDDLE <b>Evans</b> LAST <b>Evans</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Martha</b> MIDDLE <b>Rackley</b> LAST <b>Rackley</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218 52 0559</b>		17 INFORMANT <b>Mr. Charles Hartman</b> ADDRESS <b>2525 Sams Creek Road Westminster, MD. 21157</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>DIGOXIN TOXICITY AND PNEUMONIA</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>2 wks</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>8 Oct 1980</b> to <b>28 Feb 1984</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>28 Feb 1984</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) did not view the body after death.							
22b. SIGNATURE <b>ARTHUR M. WELSH MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/28/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>3640 FORDS LANE 21215</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>				25a. DATE REC'D. BY REGISTRAR <b>MAR 2 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rodriguez</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner has determined that the death was caused by injury, or other traumatic event, the medical examiner has determined that the death was caused by injury, or other traumatic event, the medical examiner has determined that the death was caused by injury, or other traumatic event.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LILLIAN G. HERSHNER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>February 17, 1984</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 17, 1914</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8409 A Nunley Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Ochsner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilma L. Schuth</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>488-12-2286</b>		17. INFORMANT ADDRESS <b>Mr. John F. Hershner same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure + Arrhythmia</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Art. C.U.D. &amp; MI</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>moments</b> <b>2 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-18</b> , 19 <b>65</b> , to <b>2-17</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>1-26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Franklin E. Leslie, M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/17/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>3501 St. Paul Street</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/20/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson Maryland</b>	
24. FUNERAL DIRECTOR <b>Ruek Towson Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>			
25b. REGISTRAR'S SIGNATURE <b>John Harrison-Randall</b>							

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January 17, 1964

MEMORANDUM

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mathilda HERTING</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 14, 1984</b>			2b. HOUR 5:00a <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-6-1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Book Binding</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4017 Parkside Drive - 21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herrui Schafen</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Heise</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-28-1738</b>		17. INFORMANT ADDRESS <b>George F. Schafen - 2110 Graythorn Rd. - 21220</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Pneumonia, Severe Periplural Vascular Disease</b> (c) <b>probable Coronary Artery Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>February 13, 1984</b> to <b>February 14, 1984</b> , that (I) (we) lost saw the deceased alive on <b>February 14, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Marsha Snyder</b>				22c. DATE SIGNED <b>2/14/84</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marsha Snyder</b>				22e. ADDRESS <b>Franklin Square Hosp. 9000 Franklin Sq. Rosedale Md Dr. 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-17-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd. - 21206</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Record may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1- FOR Item #5 Film #G589 STATE REGISTRAR 3/15/84 jp				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Sophia M HESS				February 26, 1984		2b. HOUR 10:27A	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 24 84-95		6. AGE (IN YEARS LAST BIRTHDAY) 88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY homemaking	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Reiners				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Schroeder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 220-50-3239		17. INFORMANT 4403 Ridge Rd. Ernest Hess Balto., Md. 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest, Congestive Heart Failure</b> 2089 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 25, 19 84, to February 26, 19 84, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on February 26, 19 84, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE Tommy T. Hsu M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tommy Hsu, M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-29-84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery (21236)		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR L. S. H. 7401 1/2 1/2 1/2 1/2				25a. DATE REC'D. BY REGISTRAR MAR 01 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

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MEMORANDUM FOR THE DIRECTOR

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <u>DORA NAOMI Heyman</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>2 24 84</u>		2b. HOUR <u>7:10 PM</u>
3. SEX <u>FEMALE</u>	4. RACE <u>WHITE</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>OCT. 31, 1893</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>90</u> YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MARYLAND</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTIMORE COUNTY MD.</u>		
10. CITY OR TOWN OF DEATH <u>PIKESVILLE</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>PIKESVILLE NURSING HOME</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>SALES LADY</u>	12b. KIND OF BUSINESS OR INDUSTRY <u>BLANKS DEPT. STORE</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MARYLAND</u> 13b. CITY OR TOWN <u>BALTIMORE</u>			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <u>LEWIS</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>unknown</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>214-22-8579</u>	17. INFORMANT ADDRESS <u>MRS. ESTHER SCHKLOVEN 5704 RUSK AVE. #21215</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

5728

IMMEDIATE CAUSE (a) Cardiorespiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Cardiovascular Disease of aortic Heart Failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Hepatic Failure

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Endless

Years

Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION <u>—</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>—</u> P.M. <u>19</u>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from July 1968, to February 24 1984, that (I) ~~was~~ lost  
saw the deceased alive on February 24 1984, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated  
above, ~~that~~ (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Herman Brecher M.D.</u>	DEGREE	22c. DATE SIGNED <u>2/25/84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Herman Brecher, M.D.</u>	22e. ADDRESS <u>6410 Windsor Mill Rd. 21207</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	23b. DATE <u>2-26-84</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE HEBREW Cem</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>REISTERSTOWN BALTO. MD</u>
24. FUNERAL DIRECTOR NAME <u>SOL LEVINSON &amp; BROS., INC.</u> ADDRESS <u>6010 REISTERSTOWN RD., BALTO., MD 21215</u>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>FEB 29 1984 Julia Davidson-Handall</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD C. HIEBER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 14 1984</b>		2b. HOUR <b>9:12</b> <b>AM</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MO DAY YEAR <b>July 28 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fire Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dispatcher</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Hieber</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Wonderly</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>214-40-5991</b>		17. INFORMANT ADDRESS <b>Mrs. M. N. Hieber 1001 Evesham Ave 21212</b>	

18. CAUSE OF DEATH (Enter only one cause per line for part I, 16a, and 18.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>1/22/84</b> , 19____, to <b>2/14/84</b> , 19____, that (I) (we) last saw the deceased alive on <b>2/13/84</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <b>M. O'Quinn</b>	DEGREE <b>MD</b>	22c. DATE SIGNED <b>2/14/84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MONTON C. O'QUINN</b>	22e. ADDRESS <b>2936 E. BALTIMORE ST 21224</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2-17-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Maryland</b>
24. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>	
ADDRESS <b>6500 York Road 21212</b>		25b. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 4 5 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rosalie Bumba HOLECK			2a. DATE OF DEATH MONTH DAY YEAR February 23, 1984			2b. HOUR 8:45p <sub>M</sub>	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUG. 11 1893		6. AGE (IN YEARS LAST BIRTHDAY) 90	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN PERRY HALL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB BUMBA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA DUBCEK		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 213-48-9955		17. INFORMANT ADDRESS ANNA MENTLIK (DGHTR) SAME ADDRESS					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiorespiratory Arrest

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) Ruptured aortic aneurism

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 23, 1984, to February 23, 1984, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 23, 1984, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.							
22b. SIGNATURE <i>Jeffrey Wallace</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Jeffrey Wallace, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/26/84		23c. NAME OF CEMETERY OR CREMATORY Trinity Luth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Joppa Md.	
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 9705 Belair Rd., Balto. Md. 21236				25a. DATE REC'D. BY REGISTRAR FEB 28 1984		25b. REGISTRAR'S SIGNATURE <i>John William Wendell</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after funeral with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner on the body should be notified.

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

3 4 5 3

 FOR  
 1 - STATE  
 REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Bessie L. Hopwood</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>February 2, 1984</i>		2b. HOUR M
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>January 8, 1920</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>64</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>10114 Liberty Road 21133</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tube Maker Maryland Cup</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Owings Mills</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>41 Fennington Circle 21117</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Arthur William Wingfield</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carrie Page</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-07-5550</i>		17. INFORMANT ADDRESS <i>Mrs. Dolores Virginia Capps</i> <i>10114 Liberty Road Randallstown, MD. 21133</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4140</i> IMMEDIATE CAUSE (a) <i>Crownary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i> <i>Years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>5-22-64</i> , 19 <i>84</i> , to <i>2-2</i> , 19 <i>84</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>2-1</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) ( <del>did not</del> ) view the body after death.					
22b. SIGNATURE <i>C. E. McWilliams M.D.</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2-3-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Clarence McWilliams</i>		22e. ADDRESS <i>11904 Reisterstown Road</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>Feb. 6, 84</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Foring Byers Funeral Directors, INC.</i> <i>8728 Liberty Road Randallstown, MD 21133-4784</i>		ADDRESS <i>8728 Liberty Road Randallstown, MD 21133-4784</i>		25a. DATE RECD. BY REGISTRAR <i>FEB 3 1984</i>	25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked at item 18, state any injury, or other traumatic event, the medical examiner must be notified at once.

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[Faint, mostly illegible text across the page, possibly bleed-through from the reverse side. Some words like "BIBLIOGRAPHY" and "REFERENCES" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 19b shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										0 3 4 5 4			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Thomas						HORNER		February 25, 1984					2:02P <sup>M</sup>
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		NOV. 20 1903		80		MONTHS		DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD.		U.S.A.				Baltimore County,						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		Franklin Square Hospital		Truck Driver		Balto. City							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Md.		-		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4202 Bayonne Ave. 21206					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
unknown		unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no		218-12-4548		Helen Horner (wife) same address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Invasive Adenocarcinoma of Stomach and Esophagus (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that X (this hospital) attended the deceased from January 31, 19 84, to February 25, 19 84, that X (we) last saw the deceased alive on February 25, 19 84, and that in X (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED							
Robert Wiedefeld, M.D.						2/25/84							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Robert Wiedefeld, M.D.		9000 Franklin Square Drive 21237											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		2/28/84		Gardens of Faith		Baltimore						Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213		FEB 28 1984		Julia Davidson-Randall									

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified alone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										03455			
1- FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Charles N. Horst					2a. DATE OF DEATH 2/2/84			2b. HOUR 8 P. M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7 20 18		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Rosedale		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1823 Hanford Rd. 21237				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steelworker			12b. KIND OF BUSINESS OR INDUSTRY Eastern S.S.				
13a. STATE Maryland				13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1823 Hanford Rd. 21237			
14. FATHER'S NAME Charles C. Horst					15. MOTHER'S MAIDEN NAME Lena A.								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 212-01-9170		17. INFORMANT ADDRESS 1823 Hanford Rd. Thelma B. Horst Balto., Md. 21237							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SMALL CELL CARCINOMA OF LUNG, METASTATIC</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>⑤ HEMISPHERE CEREBROVASCULAR ACCIDENT</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
19a. DATE OF OPERATION N/A			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A N/A 19		21c. HOW INJURY OCCURRED (NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> AT HOME <input checked="" type="checkbox"/> N/A			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A								
22a. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>77</u> , to <u>11/30</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>11/30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Michael R. Camp, M.D.					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 2/3/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Camp					22e. ADDRESS Suite 205 Med. Arts Bldg. 9101 Franklin Sq. Dr.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-6-84		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home					7401 Belair Rd. Balto., Md. 21236		25a. DATE REC'D. BY REGISTRAR EB 09 1984					25b. REGISTRAR'S SIGNATURE John J. [Signature]	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA E. HOSAGE			2a. DATE OF DEATH MONTH DAY YEAR 2 5 84		2b. HOUR 2 35 A M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3 10 '04		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CO. MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE MD.		13b. COUNTY BALTO.	13c. CITY OR TOWN LUTHERVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 113 RIDGEFIELD RD. 21093
14. FATHER'S NAME FIRST MIDDLE LAST Michael Mondulick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hudak		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 189-05-3525A		17. INFORMANT ADDRESS Mrs. Anne H. Yakel 113 Ridgefield Rd. 21093	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bilateral Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: \_\_\_\_\_

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>JAN 22</u> , 19 <u>84</u> , to <u>FEB 5th</u> , 19 <u>84</u> , that (we) lost saw the deceased alive on <u>FEB 5th</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Charles Hutton</u>		DEGREE M.D.		22c. DATE SIGNED 2/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES HUTTON		22e. ADDRESS 7600 OSLER DR TOWSON MD 21204			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 2-7-1984	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Maryland
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 7 1984	25b. REGISTRAR'S SIGNATURE <u>John J. Cawley</u>



30th AUGUST

15th OCT 1944

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

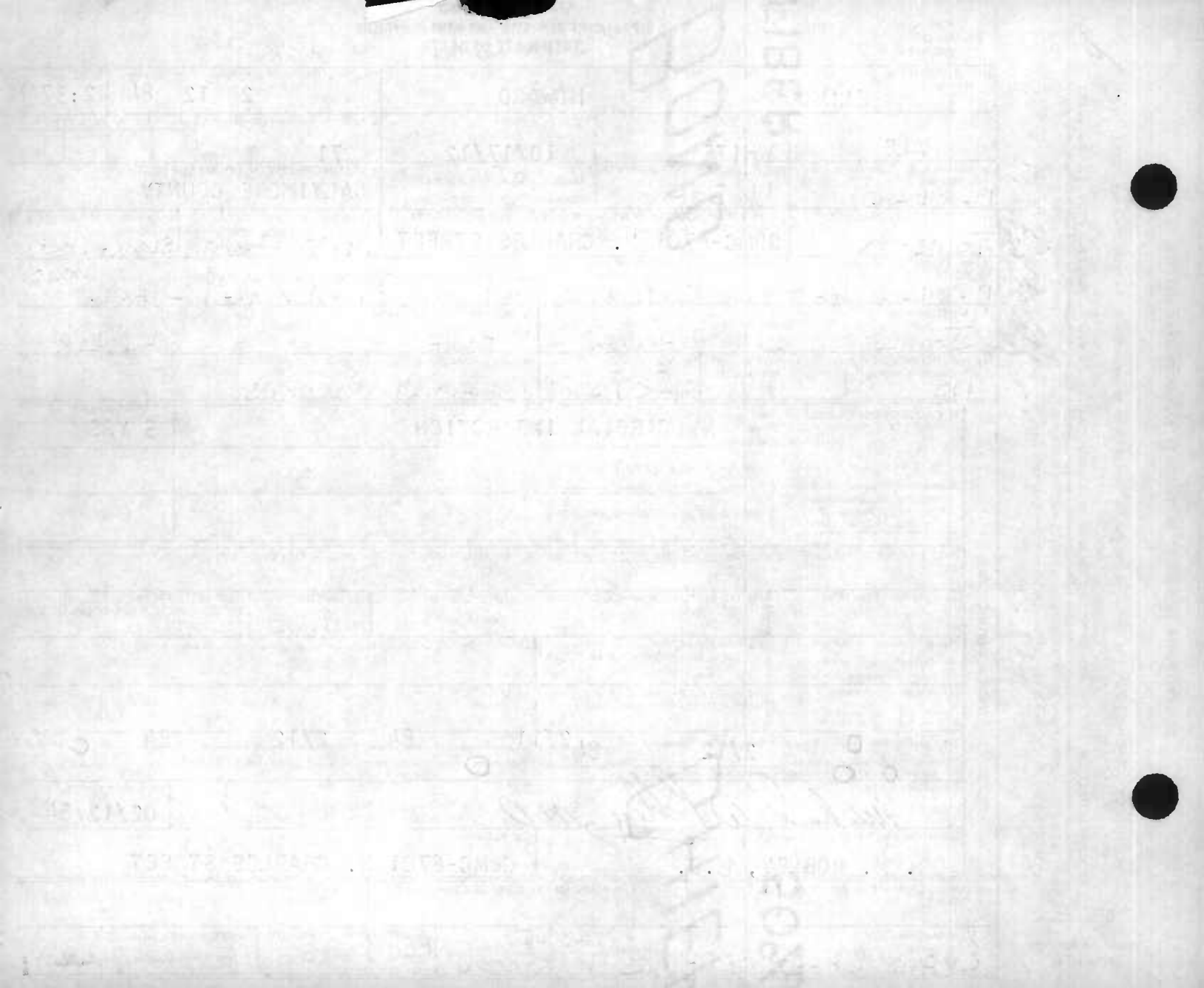
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **Medical**, item 18 shows any injury, or other traumatic event, the medical examiner must be notified by once.

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DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		0 3 4 5 7 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) ELLWOOD HOWARD				2a. DATE OF DEATH MONTH DAY YEAR 2 12 84		2b. HOUR 2:37AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10/17/12		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC-6701 N. CHARLES STREET				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEPT. FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY BLACK + DECKER	
13a. STATE Maryland				13b. COUNTY BALTIMORE		13c. CITY OR TOWN Cockeysville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES S. HOWARD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA SHILLER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 216 07 3908		17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4120 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 YRS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/11/84 to 2/12/84, that (I) (we) last saw the deceased alive on 2/12/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Michael W. Robley, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 02/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. M. ROBLEY, M.D.				22e. ADDRESS GBMC-6701 N. CHARLES STREET					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS EVANS CHAPLOF CHIMES YORK ROAD 2325				25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE William W. Wadsworth-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other," it shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Lee Howard</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Feb. 8-84</b>			
3. SEX <b>Male</b>				2b. HOUR <b>5:50 AM</b>			
4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 15 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>County</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Tawes Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Institutional</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>45 yrs</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		16. STREET ADDRESS <b>Fred &amp; Wade Ave. 21228</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>218-62-2055</b>		17. INFORMANT ADDRESS <b>Spring Grove Hosp. Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Organic Brain Syndrome</b> <b>3109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Semility</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 - 14 19 74</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if this hospital) attended the deceased from <b>11 - 14 19 74</b> , to <b>2 - 8 - 19 84</b> , that (if we) lost saw the deceased alive on <b>2 - 8 - 19 84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (if we) did (did not) view the body after death.							
22b. SIGNATURE <b>H. Devadoss</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-8-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. Devadoss</b>		MD.		22e. ADDRESS <b>Tawes / BB Spring Grove Hosp.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-9-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard</b>	
24. FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>		ADDRESS <b>Catonsville, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1984</b>			
				25b. REGISTRAR'S SIGNATURE <b>James J. Connel</b>			

BP

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ralph HOWARD			2a. DATE OF DEATH MONTH DAY YEAR February 12, 1984		2b. HOUR 12:43P <sub>M</sub>
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4 / 26 / 91		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY UNK
13a. STATE MD	13b. COUNTY BALTO	13c. CITY OR TOWN MIDDLE RIVER	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11130 BIRD RIVER EA. RD 21220	
14. FATHER'S NAME FIRST MIDDLE LAST GRANVILLE HOWARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESSIE EVANS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK		16b. SOCIAL SECURITY NO. 220 01 4999		17. INFORMANT ADDRESS JESSE HOWARD ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that X (this hospital) attended the deceased from February 12, 19 84, to February 12, 19 84, that X (we) lost saw the deceased alive on February 12, 19 84, and that in X (my) (our) opinion death occurred on the date and hour and from the causes stated above. X (we) (did) (do not) view the body after death.					
22b. SIGNATURE Michael Heller		DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 2/12/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Heller, M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 2/14/84	23c. NAME OF CEMETERY OR CREMATORY SECURITY PROCESS		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY		ADDRESS 300 MAZE		25a. DATE REC'D. BY REGISTRAR FEB 16 1984	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3460			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LELA G. Huey				2a. DATE OF DEATH MONTH DAY YEAR 2/12/84			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 12 02		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto County MD.	
10. CITY OR TOWN OF DEATH BALTO		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MANOL CARE ROSSVILLE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HOWARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Conners		13e. STREET ADDRESS 744 ALDORTH RD		21222	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 22018-8146		17. INFORMANT Lillian Huey		ADDRESS 744 Aldworth Rd. Balto., MD. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 minutes 6 weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 19 83, to FEBRUARY 2, 19 84, that (I) (we) lost saw the deceased alive on FEBRUARY 2, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James L. Gentry, MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES GENTRY		22e. ADDRESS FRANKLIN SQUARE HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/6/1984		23c. NAME OF CEMETERY OR CREMATORY E. Mahoning Baptist		23d. LOCATION CITY OR TOWN COUNTY STATE E. Mahoning Penn.	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.				25a. DATE REC'D. BY REGISTRAR FEB 7 1984		25b. REGISTRAR'S SIGNATURE John J. Connel	
7922 Wise Avenue Dundalk, MD 21222							

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3461

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Verna V. Imwald			2a. DATE OF DEATH MONTH DAY YEAR 2 22 84			2b. HOUR 11:40 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 15 08		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Maryland/Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Monkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Earl Duncan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Hubbard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-32-4605		17. INFORMANT ADDRESS Louis S. Imwald - Same as #13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Aspiration PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Possible uterine carcinoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION							
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 81 to 2/19 19 84, that (I) (we) last saw the deceased alive on 2/19 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.							
22b. SIGNATURE Larry A. Wilson MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/22/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LARRY A. Wilson MD.		22e. ADDRESS 3313 Paper Mill Rd, Phoenix Md 21131					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-25-84		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc.		ADDRESS 1050 York Rd. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR FEB 27 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 8 shows any injury, or other traumatic event, the medical examiner must be notified on page 2.

Rich Towson Funeral Home, Inc. Towson, Md. 21204

1050 York Rd.

Lake View Memorial

Baltimore

Maryland

Funeral

2-25-64

Lake View Memorial

2-25-64

2-25-64

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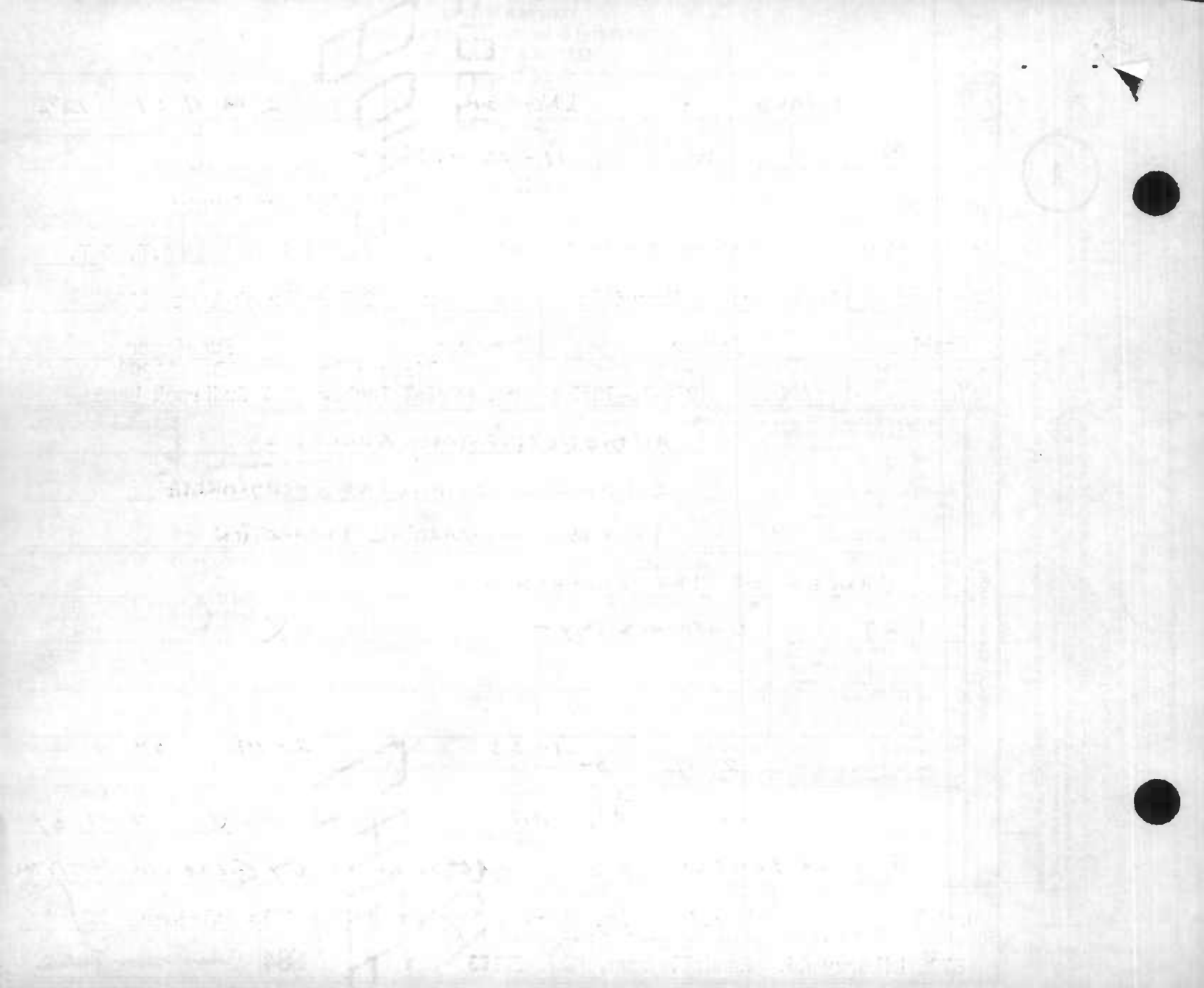
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 has any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		3 4 6 2 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
EDWARD		P		INGBER				2 17 84		12 42 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
M		W		MONTH DAY YEAR 11 - 20 - 15		68 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		USA				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Randallstown		Baltimore County General Hosp.						Technician		A.T. & T.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
Maryland		Baltimore		Pikesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		227 Sudbrook Lane 21208			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Charles Ingber				Margaret Kueninger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes WW 2				084-10-7853		Pikesville MD 21208 Mrs. Muriel Ingber 227 Sudbrook Lane					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST.</u> <u>5309</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SUSTAINED VENTRICULAR TACHYCARDIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PROBABLE MYOCARDIAL INFARCTION</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>CANCER OF THE ESOPHAGUS.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
1/27		ESOPHAGECTOMY -				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1-23</u> , 19 <u>84</u> , to <u>2-17</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2-17</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
		MD						2-17-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
IZ. DEPESTRE MD.		BALTIMORE COUNTY GENERAL HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		2/20/84		St. Charles Cemetery		Pikesville Baltimore MD					
24. FUNERAL DIRECTOR											
NAME Loring Byers Funeral Directors, Inc. ADDRESS 8728 Liberty Rd. Randallstown, MD 21133											
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
FEB 17 1984						Julia Davidson-Randall					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 3463	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ARTHUR G. JACOBSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>February 27, 1984</b>			2b. HOUR <b>Unknown</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 25, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3444 Carriage Hill Circle-Apt. 202</b>				12a. USUAL OCCUPATION <b>Retired</b> KIND OF BUSINESS OR TYPE OF WORK FOR MOST OF WORKING LIFE <b>Safety Supervisor - Brothers</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Randallstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3444 Carriage Hill Circle 21133</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gustaf Lars Jacobson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hilma Pauline Selander</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>092-07-6973</b>		17. INFORMANT <b>9 Rolling Greens Ct. Barbara Thayer - Lutherville, Md. 21093</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 ① Acute Myocardial Infarction</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
DUE TO, OR AS A CONSEQUENCE OF ② Atherosclerotic Heart Disease, Atrial Fibrillation										<b>unknown</b>	
DUE TO, OR AS A CONSEQUENCE OF ③ Aortic Regurgitation ④ Hypertension										<b>unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>Nov 5, 1948</b> to <b>2/27/84</b> , 19____, that (I) <del>met</del> <b>saw</b> the deceased alive on <b>2/19/1983</b> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>immediately</del> did not <del>saw</del> the body after death.											
22b. SIGNATURE <b>Martin Singewald M.D.</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/28/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Martin Singewald M.D.</b>				22e. ADDRESS <b>11 E Chase St Baltimore Md 21202</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3/2/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Md.</b>			
24. FUNERAL DIRECTOR NAME <b>M. &amp; Russell C. Witzke Funeral Homes P.A.</b> ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>						25a. DATE REC'D. BY REGISTRAR <b>MAR 1 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>			

100-100000

Handwritten notes and stamps, including "100-100000" and "100-100000".



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VIRGINIA W JENKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 4, 1984</b>		2b. HOUR <b>1:15P M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 2 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OFFICER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING BUS.</b>	
13a. STATE <b>MD</b>	13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>CARNEY</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3208 E. JOPPA ROAD 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM S. WILSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LYDIA M. MORRISON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>A12-26-3430</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>early</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>COPI</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <b>OCT 7 1976</b> to <b>FEB 4 1984</b> , that (1) (we) last saw the deceased alive on <b>JAN 27 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.					
22b. SIGNATURE <b>J. DAVID NAGEL MD.</b>		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>1205 YORK ROAD LUTHERVILLE MD 21093</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>FEB 8 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>DRUID RIDGE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>PIKESVILLE BALTO MD.</b>	
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPEL OF MEMORIES</b>		ADDRESS <b>8800 HARFORD RD</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 6 1984</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>

BP \_\_\_\_\_





1. DECEASED NAME (TYPE OR PRINT)		FIRST ALLAN		MIDDLE WILLIAM		LAST JOHNSON		26. DATE OF DEATH MONTH DAY YEAR FEBRUARY 21, 1984		26. HOUR 12:45 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 11, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD					
10. CITY OR TOWN OF DEATH FORT HOWARD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. ARMY OFFICER			12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 703 THORNWOOD COURT 21204			
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM H. JOHNSON				15. MOTHER'S MAIDEN NAME MIDDLE LAST CHRISTY ANN CAMARON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. W-10 POST KOREAN 271 07 9567		17. INFORMANT ADDRESS RICHARD C. JOHNSON - SAME AS 13e. CLINICAL RECORDS, VAMC, FORT HOWARD, MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR YEARS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OLD CEREBROVASCULAR ACCIDENT											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 20, 1984, to FEBRUARY 21, 1984, that (I) (we) lost saw the deceased alive on FEBRUARY 21, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Peter Juvan						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/21/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER J. JUVAN, M.D.						22e. ADDRESS VA MEDICAL CENTER, FORT HOWARD, MD 21052					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/22/1984		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND					
24. FUNERAL DIRECTOR NAME ADDRESS WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222						25a. DATE REC'D. BY REGISTRAR FEB 24 1984		25b. REGISTRAR'S SIGNATURE [Signature]			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1, AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Isaac (NMN) Johnson</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>2 7 19 84</b>			2b. HOUR <b>M</b>		
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 30, 1900</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>83</b> YRS.	IF UNDER 1 YR. MONTHS DAYS <b>6 7</b>	IF UNDER 24 HRS. HOURS MIN <b></b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2 7 19 84</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>18 Roberts Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>18 Roberts Ave. (21228)</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walker Johnson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Lewis</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-30-6444</b>		17. INFORMANT <b>James C. Johnson, 24 Shipley Ave. Baltimore, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Smoke and soot inhalation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:30xx 2 7 19 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>House fire</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>18 Roberts Avenue, Catonsville, Balto, Md.</b>			
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Thomas D. Smith</i>			TITLE (SPECIFY) <b>Deputy Chief</b>			DATE SIGNED <b>2/7/84</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>			ADDRESS <b>111 Penn St.</b>			BALTO, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-11-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Deer Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Carroll, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Charles W. Burrier, Jr., Sykesville, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

RECEIVED  
JUN 10 1964

James A. Sullivan, Jr., Xenia, Ohio, 45385  
Miss Mary Ann Sullivan

James A. Sullivan, Jr., Xenia, Ohio, 45385  
Miss Mary Ann Sullivan  
Xenia, Ohio, 45385  
James A. Sullivan, Jr., Xenia, Ohio, 45385  
Miss Mary Ann Sullivan

James A. Sullivan, Jr., Xenia, Ohio, 45385  
Miss Mary Ann Sullivan  
Xenia, Ohio, 45385  
James A. Sullivan, Jr., Xenia, Ohio, 45385  
Miss Mary Ann Sullivan

James A. Sullivan, Jr., Xenia, Ohio, 45385  
Miss Mary Ann Sullivan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 4 6 7	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Margaret Ruth Johnson</b>						2a. DATE OF DEATH MONTH <b>02</b> DAY <b>11</b> YEAR <b>84</b>			2b. HOUR <b>10:10 P.</b>		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>05</b> DAY <b>20</b> YEAR <b>07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meridian Nursing Ctr.-Catonsville</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b></b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>3409 Janellen Drive 21208</b>			
14. FATHER'S NAME FIRST <b>Peter</b> MIDDLE <b>A.</b> LAST <b>Johnson</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Martha</b> MIDDLE <b>Ellen</b> LAST <b>Harmon</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-30-4107</b>		17. INFORMANT ADDRESS <b>Martha Harris 1148 N. Calhoun St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5860</b> IMMEDIATE CAUSE (a) <b>CVA-second CTG-R.U.D</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal failure - Lysine Sdpe</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3-12-84</b> , 19 <b>84</b> , to <b>2-11-84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2-11-84</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>George Angra</b>				DEGREE				ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-13-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE ANGRA</b>				22e. ADDRESS <b>3350 Wilkens Dr. Baltimore 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2-16-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b>Md.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Carlton C. Douglass</b> ADDRESS <b>664-1738 1012 Penn Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LEO</b> <b>R.</b> <b>JONAS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 17, 1984</b>		2b. HOUR <b>2:35 A.M.</b>
3 SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 25 1909</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Consultant</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Business</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>7700 Greenview Terrace 21204</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fritz Jonas</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Albertie</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-38-9226</b>	17. INFORMANT <b>Barbara Jonas 7700 Greenview Terrace</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **4410**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**weeks**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from <b>2-17</b> , 19 <b>84</b> , to <b>2-18</b> , 19 <b>84</b> , that (X) (we) lost saw the deceased alive on above, (X) (we) (did) (not) view the body after death.			
22b. SIGNATURE <b>Maurice Burlong Jr</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>2-17-84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MAURICE BURLONG JR</b>		22e. ADDRESS <b>ST JOSEPH HOSPITAL</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 20, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 21 1984</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Dolores M. Jones</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 19, 1984</b>		2b. HOUR <b>2:45 A.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 31, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>late George Milholland</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>late Ella Gordon</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212 42 0276</b>		17. INFORMANT ADDRESS <b>21043 Mrs Joseph Stine 3106 Greenway Ellicott City</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>5070</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>8-30-83</b> , 19 <b>84</b> , to <b>2-19</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>2-16</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Eddie Nakhuda</b>		DEGREE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb 21 '84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulany Valley Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 22 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP

Harry H. Wicks 412 Columbia Baltimore City

Feb 21 '84 Dulany Valley Gardens

Baltimore Maryland

No

212 41 0276

Mrs Joseph Stine 3106 Greenway

21043

Baltimore City

face George Williamson

Jane Ellis Gordon

Maryland Baltimore Towson

x

Dulany Valley Rd 21204  
Stella Marie

Honolulu

Maryland U.S.A.

x

Oct. 21, 1903

White

Female

80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	P
Irene May KACALA					February 16, 1984					3:45	M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female	White	MONTH DAY YEAR 1 23 12			72 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Delaware	U.S.				Baltimore County MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Balto. County		Franklin Square Hosp.			Cashier		Grocery				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md.				Balto.		YES <input type="checkbox"/> NO <input type="checkbox"/>		1652 Poles Road 21221			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				220-24-7846		Mr. Charles A. Boulden 4322 Ivy Glen Rd. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
<u>Acute bronchitis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>Feb. 16</u> , 19 <u>84</u> , to <u>Feb. 16</u> , 19 <u>84</u> , that (we) last saw the deceased alive on <u>Feb. 16</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) did not see the body after death.											
22b. SIGNATURE <u>M. Frydenborg</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2/16/84</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Frydenborg, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 2/17/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR FEB 23 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FIBER

EDWARD

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CHIEF

FEB 23 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 4 7 1

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charles A. KAHLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 7, 1984</b>		2b. HOUR <b>9:46am</b>
1 SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 13 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rossville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Kirby Builders</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Kahler</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilhelmina Karn</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>216-10-8624A</b>		17. INFORMANT ADDRESS <b>5122 Kenwood Ave. Balto., 21206</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>Cardiac Arrest</b> <b>4100</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Atherosclerotic Coronary Vascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>February 4, 1984</b> to <b>February 7, 1984</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 7, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, or (we) (did) (do) view the body after death.					
22b. SIGNATURE <b>Joseph A. Schneider, J. MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>2/7/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph A. Schneider, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2-10-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 10 1984</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Gault</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1012

100-10-10

1017

1801

1046

337.0118 . M. 073.03



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner number should be noted on page 1.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					3 4 7 2			
1. FOR STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>RUTH</b>			FIRST <b>KAHN</b>		LAST			
2a. DATE OF DEATH <b>FEB 11, 1984</b>			MONTH <b>11</b>		YEAR <b>1984</b>			
2b. HOUR <b>750A</b>			DAY		YEAR			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 26, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>		
10. CITY OR TOWN OF DEATH <b>PIKESVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MILFORD MANOR NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST <b>PAUL</b>		MIDDLE <b>ROBINSON</b>		LAST <b>FRANCES</b>		15. MOTHER'S MAIDEN NAME FIRST <b>KAFKA</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-07-7819</b>		17. INFORMANT ADDRESS <b>MR. ARTHUR KAHN 3206 LABYRINTH RD. #21208</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Colon</b> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1131</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1984</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>1984</b>		CITY OR TOWN <b>11 Feb</b>		
22a. I certify that (I) (the hospital) attended the deceased from <b>1984</b> to <b>11 Feb</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>11/31</b> 19 <b>84</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. SIGNATURE <b>Louis H. Humberger</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/11/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOUIS H. HUMBURGER</b>		22e. ADDRESS <b>100 Mc HENRY AVE (21108)</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2-12-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW FRIENDSHIP</b>		23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>		
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>		FEB 15 1984		REGISTRAR'S SIGNATURE <b>[Signature]</b>		

BP

RECEIVED  
JAN 10 1900





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FOR Item 4 & 13a&b&c  
1- STATE REGISTRAR 3-7-84 cnDEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

3473

REG. NO. 3  
20. DATE OF DEATH MONTH DAY YEAR 2b HOUR  
02-19-84 7:47P M

1. DECEASED NAME (TYPE OR PRINT) EMILY KAUFFMAN		20. DATE OF DEATH MONTH DAY YEAR 2b HOUR 02-19-84 7:47P M	
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 02 18 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	6. AGE (IN YEARS LAST BIRTHDAY) 34HRS	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
10. CITY OR TOWN OF DEATH TOWSON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (GBMC) 6701 NORTH CHARLES STREET	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		12b. KIND OF BUSINESS OR INDUSTRY	
13b. CITY OR TOWN Baltimore		13c. STREET ADDRESS / ZIP CODE 7702 Beekay rd 21219	
14. FATHER'S NAME FIRST MIDDLE LAST Paul Edward Kaufman, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Deborah Catherine Siarkowski	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT Birth certificate		ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY FAILURE

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

10 HRS

7650

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) EXTREME PREMATURITY

DUE TO, OR AS A CONSEQUENCE OF

(c) RENAL FAILURE

12 HRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 02-18, 19 84, to 02-19-19 84, that (I) (we) lost saw the deceased alive on 02-19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE M. Gary Karłowicz		DEGREE MD	22c. DATE SIGNED 2/20/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M GARY KARLOWICZ		22e. ADDRESS 6701 NORTH CHARLES STREET (GBMC)	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) HOSPITAL DISCARD	23b. DATE 2/22/84	23c. NAME OF CEMETERY OR CREMATORY GBMC	23d. LOCATION CITY OR TOWN COUNTY STATE Towson Baltimore MD
24. FUNERAL DIRECTOR NAME John E Adams		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 06 1984 John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03474

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Sarah Agnes KEARNEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 23, 1984</b>		2b. HOUR <b>5:46P</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 27 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas E. Grogan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Brannan</b>		13e. STREET ADDRESS / ZIP CODE <b>7100 Park Place 21234</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT ADDRESS <b>James G. Kearney 2701 Kildaire Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Atherosclerotic Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>June 1-6</u> , 19 <u>84</u> , to <u>2-23</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>1-6</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Marion C. Kowalewski</b>		DEGREE <b>M.D.</b>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/24/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marion C. Kowalewski, M.D.</b>		22e. ADDRESS <b>8604 Harford Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>		23b. DATE <b>Feb. 27, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. Baltimore, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1984</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 03475	
1. DECEASED NAME (TYPE OR PRINT) John C. KELLY SR.			2a. DATE OF DEATH MONTH DAY YEAR February 8, 1984		2b. HOUR a.m. 12:45	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR May 10, 1900	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH A CITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTNANCE ENG.		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4 Elmort Ave 21206
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Kelly		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henny Hennan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-10-3320		17. INFORMANT ADDRESS Baltimore, Md. Lorraine Hacke 4234 Soth Ave. 21236		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumothorax 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) Intubation DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory failure 2 <sup>o</sup> to COPD						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (this hospital) attended the deceased from February 2, 1984, to February 8, 1984, that (we) lost saw the deceased alive on February 7, 1984, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.						
22b. SIGNATURE S.D. 088 DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED Feb 8, 1984		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Fred Dressler, M.D.				22e. ADDRESS 9000 Franklin Square Dr., Balto., 21237		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb 10, 84		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem. Baltimore, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Dippel Funeral Homes, Inc. ADDRESS 7110 Belair Road Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR FEB 9 1984		25b. REGISTRAR'S SIGNATURE John J. Conner

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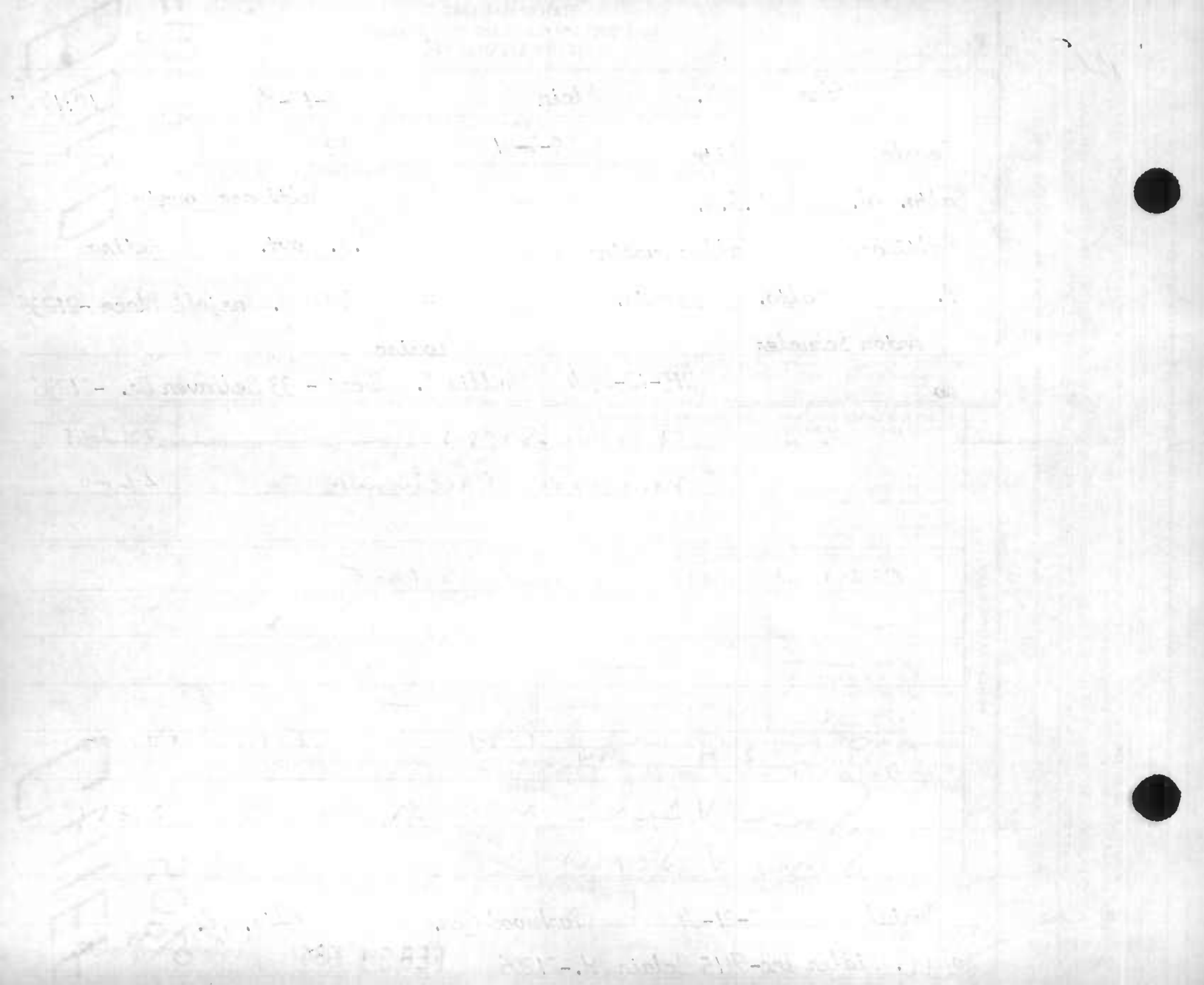
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03477

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SHIRLEY KOREN			2a. DATE OF DEATH MONTH DAY YEAR FEB 8, 1984			2b. HOUR 9:30 A M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APR. 8, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH RANDALLSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY SHERMAN LAB		
13a. STATE MARYLAND			13b. CITY BALTIMORE		13c. CITY OR TOWN OWINGS MILLS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4B SIERRA CIR. #21117	
14. FATHER'S NAME FIRST MIDDLE LAST BENNY FEIT			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA HUBBERMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-30-7900		17. INFORMANT MR. IRVIN ADAMS 8 MORROW CT. RANDALLSTOWN, MD 21133					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Ventricular fibrillation.</u> (b) <u>Hypertension.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 7</u> , 19 <u>84</u> to <u>Feb 8</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Feb 7</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Rapael Perez-Mera</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-8-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAPAEL PEREZ-MERA			22e. ADDRESS 5400 OLD COURT Rd							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE FEB. 10, 1984		23c. NAME OF CEMETERY OR CREMATORY AGUDAS ACHIM ANSHE SFARD		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1a. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
FIRST MIDDLE LAST			LAURA BLISS KROENING		2 - 2 - 84 112P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. HOUR		
Female	White	10 6 95	88			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7c. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
Mississippi	USA		Baltimore County MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cockeysville	Maryland Masonic Home		Homemaker			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS		
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	718 Melville Ave. 21218		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
David Fairley		Mary Louise VanNorman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No		212-01-5872		Records-Maryland Masonic Home		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS - GENERAL						2-2-84
DUE TO, OR AS A CONSEQUENCE OF (c)						YES
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
		P.M. 19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (I) (this hospital) attended the deceased from 12-1-85, 19 75, to 2-2-84, 19, that (I) (we) lost saw the deceased alive on 2-2-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22a. SIGNATURE				DEGREE		22c. DATE SIGNED
Walter E. Karfgin, M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2-2-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
Walter E. Karfgin, M.D.				Cockeysville, Md. 21030		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Feb. 6, 1984	Baltimore National		Baltimore City, Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Mitchell-Wiedefeld Home, Inc.		6500 York Rd. Balto., Md. 21222		Feb 8 1984		John J. Givish

100-11-11-031

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 4 7 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Thomas Godfrey Kronawetter, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2 15 84</b>		2b. HOUR <b>12 P. M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 8 1911</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		
10. CITY OR TOWN OF DEATH <b>Rossville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis J. Kronawetter</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Schiebelhoffer</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Frieda F. Garman</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 30, 1979</b> to <b>Feb. 15, 1984</b> , that (I) (we) last saw the deceased alive on <b>Feb. 10, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>M. Ramsey</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2-15-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>2/18/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Funeral Home of Dundalk, Inc.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>		25a. DATE RECD. BY REGISTRAR <b>FEB 21 1984</b>		
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										03480											
1. FOR STATE REGISTRAR										REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE J. KRUG										2a. DATE OF DEATH MONTH DAY YEAR 02 02 84										2b. HOUR 2:15A M	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 05 30 24			6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.						IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.												
10. CITY OR TOWN OF DEATH LANDSOWNE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2602 GEHB AVENUE, 21227							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER				12b. KIND OF BUSINESS OR INDUSTRY ---							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND										13b. COUNTY BALTIMORE		13c. CITY OR TOWN LANDSOWNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2529 GEHB AVENUE, 21227					
14. FATHER'S NAME FIRST MIDDLE LAST VINCENT GLORIOSO					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BATTAGLIA																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 215-14-9597			17. INFORMANT ADDRESS ROBERT W. KRUG 7819 POPLAR GROVE ROAD SEVERN, MD. 21144															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respratory Arrest</u> <u>1539</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic spread of colon cancer</u> (c) <u>colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u> <u>6 Month</u> <u>4 years</u>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>																					
19a. DATE OF OPERATION 12-8-81			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Colon Cancer					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22. I certify that (I) (this hospital) attended the deceased from <u>11-20</u> , 19 <u>81</u> , to <u>1-23</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>1-23</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
23. SIGNATURE <u>William P. Reed</u>						DEGREE <u>MD</u>				23c. DATE SIGNED <u>2/3/84</u>											
23b. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM P. REED, M.D.						23c. ADDRESS UNIVERSITY OF MARYLAND, 22 S. GREENE STREET 21229															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 02-04-84		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. PARK				23d. LOCATION CITY OR TOWN COUNTY STATE GLEN BURNIE A.A. MARYLAND												
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.						ADDRESS 4107 WILKENS AVE.		25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 03481				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marjory MATTHEWS Lamb					2a. DATE OF DEATH MONTH DAY YEAR 2 2 84 2b. HOUR 9:35 a.m.				
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 28 1885		6. AGE (IN YEARS LAST BIRTHDAY) 98 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Cockeysville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Broadmead				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN Cockeysville					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 904 DULANEY VALLEY CT. 13801 York Road 21204		
14. FATHER'S NAME FIRST MIDDLE LAST Charles T. Matthews					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret K. WOOLSTON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. 215-28-9659D		17. INFORMANT ADDRESS ELIZABETH L. BUCK 1405 WALNUT HILL LANE 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 2989 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PNEUMONIA - LEFT LOWER LOBE (c) ORGANIC MENTAL SYNDROME									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE - RECURRENT URINARY TRACT INFECTION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAY 20 19 81 to FEBRUARY 2 19 84, that (I) (we) lost saw the deceased alive on FEBRUARY 2 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Walter R. Hepner III				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/2/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Walter R. Hepner III				22e. ADDRESS 3313 PAPER MILL ROAD 21234					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2/3/84		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD			
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. BALTO., MD 21222				25a. DATE REC'D. BY REGISTRAR FEB 3 1984		25b. REGISTRAR'S SIGNATURE			

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NOTES

1. The first thing I noticed when I stepped out of the plane was the cold. It was a sharp contrast to the warm air of the airport. I shivered slightly, pulling my coat tighter around me. The ground was covered in a thin layer of snow, and the trees in the background were bare and white.

2. As I walked towards the entrance, I saw a sign that read "Welcome to the City". It was a simple, wooden sign with the words carved into it. I smiled at it, feeling a sense of familiarity. I had been here before, and I knew exactly where I was going.

3. I found a small, cozy cafe near the entrance. The interior was warm and inviting, with soft lighting and a comfortable atmosphere. I sat at a small table and ordered a cup of coffee. The barista smiled at me, and I felt a sense of ease.

4. I spent the next hour in the cafe, watching the world go by. The snow was falling gently, and the trees were covered in a thick layer of white. I felt a sense of peace and tranquility. It was a perfect day, and I was lucky to be here.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					0 3 4 8 2				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Marguerite H. Langrall</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Feb 16, 1984</b>				2b. HOUR <b>7:25 PM</b>
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 15, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Holbrook, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Pickersgill Retirement Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FEDERAL LAND BANK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BANK</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>21210 APT 106 UNIVERSITY PLWY H-5</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James A. Harker</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Stanfield</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>313-74-216-05-1734</b>		17. INFORMANT ADDRESS <b>James H. Langrall - 606 Country Rd 31204</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced arteriosclerotic cardiovascular disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>February 14, 1984</b> to <b>February 16, 1984</b> , that (I) (we) last saw the deceased alive on <b>February 14, 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. Isabelle MacGregor</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>2-17-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. ISABELLE MACGREGOR</b>					22e. ADDRESS <b>11E CHASE STREET, BALTIMORE MD 21202</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/20/1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Duval Ridge</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore</b>		
24. FUNERAL DIRECTOR NAME <b>M. Echall-Widefeld/Homa</b>					25. DATE RECEIVED BY STATE <b>FEB 21 1984</b>				

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1. DESCRIPTION OF WORK  
The work to be performed under this contract is to provide the following services:  
a. Design and construction of a new building  
b. Construction of a new building  
c. Construction of a new building  
d. Construction of a new building  
e. Construction of a new building  
f. Construction of a new building  
g. Construction of a new building  
h. Construction of a new building  
i. Construction of a new building  
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m. Construction of a new building  
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v. Construction of a new building  
w. Construction of a new building  
x. Construction of a new building  
y. Construction of a new building  
z. Construction of a new building

2. TERMS AND CONDITIONS  
a. Price  
b. Payment  
c. Delivery  
d. Warranty  
e. Insurance  
f. Liability  
g. Force Majeure  
h. Assignment  
i. Subcontracting  
j. Dispute Resolution  
k. Termination  
l. Severability  
m. Entire Agreement  
n. Counterparts  
o. Signatures  
p. Witnesses  
q. Notarization  
r. Execution  
s. Amendments  
t. Revisions  
u. Supplements  
v. Attachments  
w. Exhibits  
x. References  
y. Definitions  
z. Other

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03483

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARY L. LAW</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 14, 1984</b>		2b. HOUR M <b>AM</b>
3 SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 11, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MILFORD MILL NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY	13c. CITY OR TOWN <b>BALTIMORE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>? ? ?</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>? ? ?</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-32-9623D</b>		17. INFORMANT ADDRESS <b>MARIAN OLETSKY 7111 PARK HEIGHTS AVE. 21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE CVA</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Barry Gold MD</b>		DEGREE		22c. DATE SIGNED <b>2/14/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY GOLD M.D.</b>		22e. ADDRESS <b>6804 PARK HEIGHTS AVE. 21215</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>FEB. 16, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL CEM.</b>	
23d. LOCATION CITY OR TOWN <b>BALTIMORE</b>		COUNTY <b>MD.</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212</b>		24. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

This certificate must be completed at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page always retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Their please remove carbon papers, pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03484		
1. DECEASED NAME (TYPE OR PRINT) MINNIE LAWRENCE			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 12 1984			2b. HOUR *8:45A M						
1. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11/23/00		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ. HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN PARKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2707 SARAH LN. 21234				
14. FATHER'S NAME FIRST MIDDLE LAST JAMES SCHWARTZ				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET HERR								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/O				16b. SOCIAL SECURITY NO. 215 40 0694		17. INFORMANT CHARLES LAWRENCE				ADDRESS ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5621 RESPIRATORY ARREST SEPSIS DUE TO, OR AS A CONSEQUENCE OF (b) DIVERTICULITIS, UTI DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: UPPER G.I. BLEEDING												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)							
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT HOME			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (this hospital) attended the deceased from FEBRUARY 9 19 84, to FEBRUARY 12 19 84, that (i) (we) last saw the deceased alive on FEBRUARY 12 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.												
22b. SIGNATURE Christopher M. Berckelmann MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher M. Berckelmann						22e. ADDRESS 9000 FRANKLIN Square Dr., BALT, MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/15/84		23c. NAME OF CEMETERY OR CREMATORY DAK LAWN			23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.				
24. FUNERAL DIRECTOR NAME J.L. CONNELLY						25a. DATE REC'D. BY REGISTRAR FEB 16 1984		25b. REGISTRAR'S SIGNATURE [Signature]				



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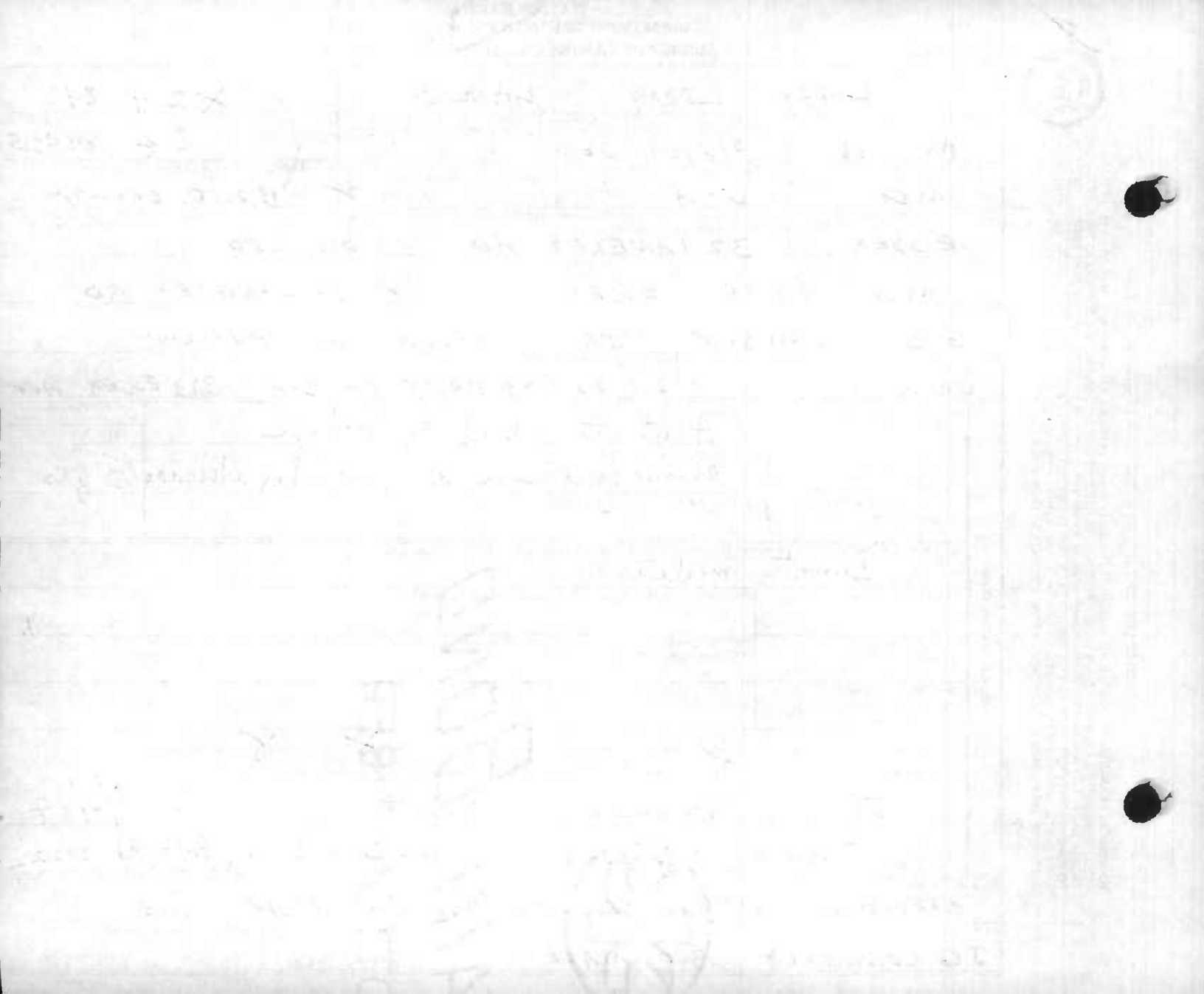


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR LEGAL COUNSEL. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 03485	
1. DECEASED NAME (TYPE OR PRINT) <b>HARRY LEROY LAWSON</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>2 4 19 84</b>		2b. HOUR <b>M</b>			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5/8/27</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>56 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2 6 19 84 0915</b>		2d. HOUR <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>ESSEX</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>32 LANGLEY RD.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DISABLED</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>32 LANGLEY RD 21221</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>GUS LAWSON JR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEN M. PHILLIPS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>UNIS</b>				16b. SOCIAL SECURITY NO. <b>219 22 7743</b>		17. INFORMANT ADDRESS <b>DAVID LAWSON 313 ESSEX AVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute intracerebral hemorrhage</b> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>chronic hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 yrs.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Diabetes mellitus</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>			TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER		DATE SIGNED <b>2/6/84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>			ADDRESS <b>2142 Dundalk Ave., Balt., Md. 21222</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>2/7/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SECURITY PROCESS</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>J.G. CONNELLY 300 MALE</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 7 1984</b>		25b. REGISTRAR'S SIGNATURE <b>George C. ...</b>			



OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 4 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GLADYS N. LAYMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 6, 1984</b>		2b. HOUR <b>3:10 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 8, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6110 Edmondson Avenue - Apt. C4</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>C. &amp; P. Telephone Co.</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Catonsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>6110 Edmondson Avenue - Apt. C4 21228</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Franklin Grill</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Keiser</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-20-8673</b>		17. INFORMANT ADDRESS <b>Mrs. Ruth Disney - Catonsville, Md. 21228</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart cell arteritis</b> <b>4730</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a). <b>ASCVD</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (we) attended the deceased from <b>1937</b> , 19____, to <b>February 6</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>Feb. 6</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>J. A. Nesbitt Jr.</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2-7-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. A. Nesbitt Jr.</b>		22e. ADDRESS <b>1009 Frederick Road, Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/9/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Randallstown Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 8 1984</b>			
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>		25. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			
26. ADDRESS <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 03481	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 2 4 84		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT LeRoy LEATHERWOOD			2b. HOUR 1445 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1930	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS. 11 21	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Clerk		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. CITY OR TOWN Sykesville		13c. STREET ADDRESS / ZIP CODE 2445 Arthur Avenue 21784	
14. FATHER'S NAME FIRST MIDDLE LAST Gurney O. Leatherwood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-26-5683		17. INFORMANT ADDRESS Betty B. Leatherwood, Same As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) SHOCK DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) CONGESTIVE CARDIOMYOPATHY DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hafeez A. Syed m.d.		DEGREE		22c. DATE SIGNED 2/4/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEEZ A SYED M.D.		22e. ADDRESS BALTIMORE COUNTY GEN HOSP.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-8-1984		23c. NAME OF CEMETERY OR CREMATORY Lakeview Memorial	
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll, Md.			
25a. DATE REC'D. BY REGISTRAR FEB 07 1984		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		0 3 4 8 8	
1. DECEASED NAME (TYPE OR PRINT)		FIRST Herve	MIDDLE (nmi)	LAST LEGENBRE	2a. DATE OF DEATH MONTH DAY YEAR 2/28/84
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 24 1901	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
QUEBEC, CANADA		U.S.A.		82	
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQUARE HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY SHIPBUILDING			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN DUNDALK	
14. FATHER'S NAME FIRST MIDDLE LAST ZEPHIRIN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST OLIVINE LEMAY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 050.10.6095		17. INFORMANT MRS. DIANNE LEGENDRE (same as 13e)		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4241 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Arrest, Atherosclerotic Coronary Vascular Disease Congestive Heart Failure (c) Aortic Stenosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 11a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from February 27, 19 84, to February 28, 19 84, that (we) lost saw the deceased alive on February 28, 19 84, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph A. Schneider, Jr. MD.		22c. DATE SIGNED 2/28/84		22d. ADDRESS 9000 Franklin Square Dr., 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/2/1984		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART OF JESUS BALTIMORE	
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. DUNDALK, MD 21222		25a. DATE REC'D. BY REGISTRAR MAR 5 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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*[Faint, mostly illegible handwritten text follows, appearing to be a letter or report.]*

MAR 2 1915



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, medical examiner must be called within 24 hours.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

0 3 4 8 9  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GLENN F. LEIDIG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 15, 1984</b>			2b. HOUR <b>4:45</b> P			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 19, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore Co.,</b> MD.			
10. CITY OR TOWN OF DEATH <b>21234</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1713 Goodview Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21234</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1713 Goodview Rd. 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Bernhard J. Leidig</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna B. Helbing</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-01-8244</b>		17. INFORMANT ADDRESS <b>Sophie W. Leidig 1713 Goodview Rd.</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER prostate</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/4 yrs</b>	
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>110</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>—</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET <b>—</b>		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>—</b> , 19 <b>—</b> , to <b>—</b> , 19 <b>—</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>—</b> , 19 <b>—</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>SS Patel</b>				DEGREE <b>—</b>		22c. DATE SIGNED <b>2/16/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SS PATEL</b>				22e. ADDRESS <b>316, 9101 Franklin Sq Drive Baltimore 21237</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/18/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery Baltimore City, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>William E. Johnson 8521 Loch Raven Bl.</b>				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 17 1984 Julia Davidson-Randall</b>			

COPIES

FILED



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

03490

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EMORY C. Lentz</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>2-22-84</b>			2b. HOUR <b>10 50 AM</b>			
1. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 11 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (PROVIDE WORK FOR WHICH WORKING IN LIFE) <b>High Tension Lineman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Powerline Construction</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Parkton</b>		13e. STREET ADDRESS / ZIP CODE <b>19518 York RD 21120</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George O. Lentz</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elva Myrtle Baker</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 180-09-4267</b>		17. INFORMANT ADDRESS <b>Elva M. Lentz, 19518 York Rd. Parkton, MD 21120</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ca of Pancreas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Erlando Romero</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/22/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ERLANDO ROMERO</b>						22e. ADDRESS <b>ST. Joseph Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb 25, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Freedom Cemetery</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>New Freedom, York, PA</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>J. J. Hartenstein, Second at Franklin Street, New Freedom, PA 17349</b>									

MEDICAL CERTIFICATION

FRANKY C. LENTZ

White

1920

2nd St. New York

1920

Frank C. Lentz

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				03491 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>BEATRICE LEVIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>FEBRUARY 14, 1984</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 3, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11 LIGHTTOWN CT. 21208</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SOLOMON POSNER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SYLVIA KATZMAN</b>		13e. STREET ADDRESS / ZIP CODE <b>11 LIGHTTOWN CT. 21208</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-74-3864</b>		17. INFORMANT ADDRESS <b>MR. SAMUEL LEVIN 11 LIGHTTOWN CT. 21208</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C A Pancreas</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>19 73</b> to <b>2/19</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>DR LEON SHEER</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/15/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR LEON SHEER</b>		22e. ADDRESS <b>6715 PARK HEIGHTS AVE.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2/16/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KOVNA CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>				25a. DATE REC'D BY REGISTRAR <b>FEB 17 1984</b>			
6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>			

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EXHIBIT

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EXHIBIT

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03492

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SARAH LICHTMAN			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 29, 1984		2b. HOUR 12:45A M
1. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 20, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH PIKESVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MILFORD MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2500 W. BELVEDERE AVE. APT. 1013 #21215	
14. FATHER'S NAME FIRST MIDDLE LAST HYMAN KENIG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-52-6448		17. INFORMANT ADDRESS HARRY LICHTMAN 6809 CHEROKEE DR. (21209)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

COLONIC CANCER METASTATIC

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

19 MONTHS

1539  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION 12-28-83	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PROLAPSED COLOSTOMY CANCER	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 28 February 1984, to 28 February 1984, that (we) lost saw the deceased alive on 28 February 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.			
22b. SIGNATURE 	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/29/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ARTHUR LEBSON		22e. ADDRESS 3640 FORDS LANE	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 3/1/84	23c. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL ANSHE KOLK CEM.	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		25a. DATE REC'D. BY REGISTRAR MAR 6 1984	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified.

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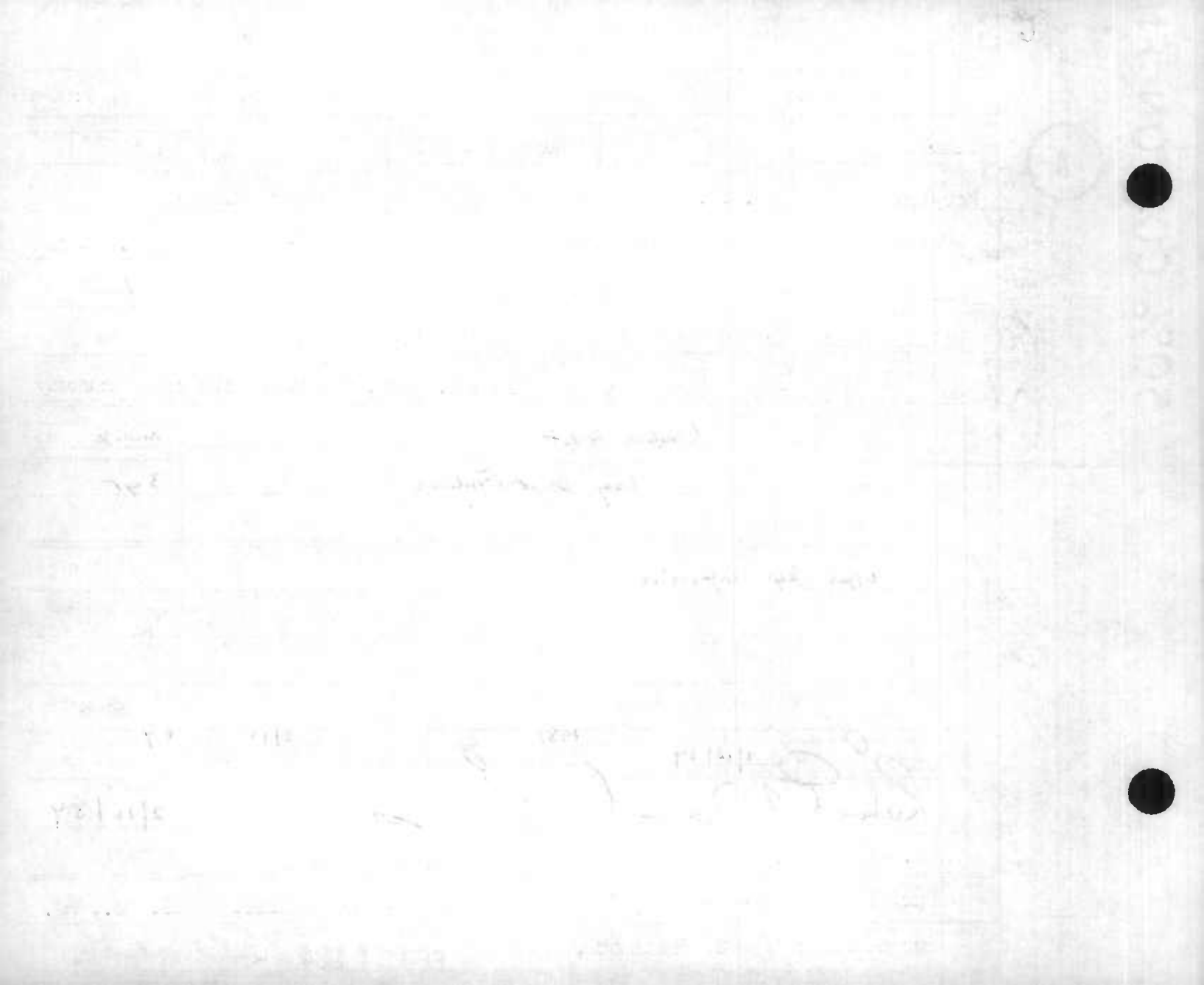
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted for a post-mortem examination.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>JANE BELLE LILICH</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 15, 1984</b>		2b. HOUR PM <b>9:00</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 28, 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Ruxton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care - Ruxton</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Saleslady</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Henry Peregoy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Virginia Hare</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
17a. SOCIAL SECURITY NO. <b>216 46 0009</b>		17. INFORMANT ADDRESS <b>Irene B. Hare, 901 West University Parkway</b>					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4280</b> <i>Conscious Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cong Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yr</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Upper Resp Infection</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from <b>1987</b> 19 <b>2/12/84</b> to <b>2/15</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>2/12/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Richard L. Diamond</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2/16/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Richard L. Diamond</b>		22e. ADDRESS <b>3547 Chestnut Avenue</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>02-18-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville, Balto. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>Burgee Funeral Home, Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>FEB 21 1984</b> <i>Julia Davidson-Randall</i>			

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03494

1- FOR  
STATE  
REGISTRAR

REG. NO.

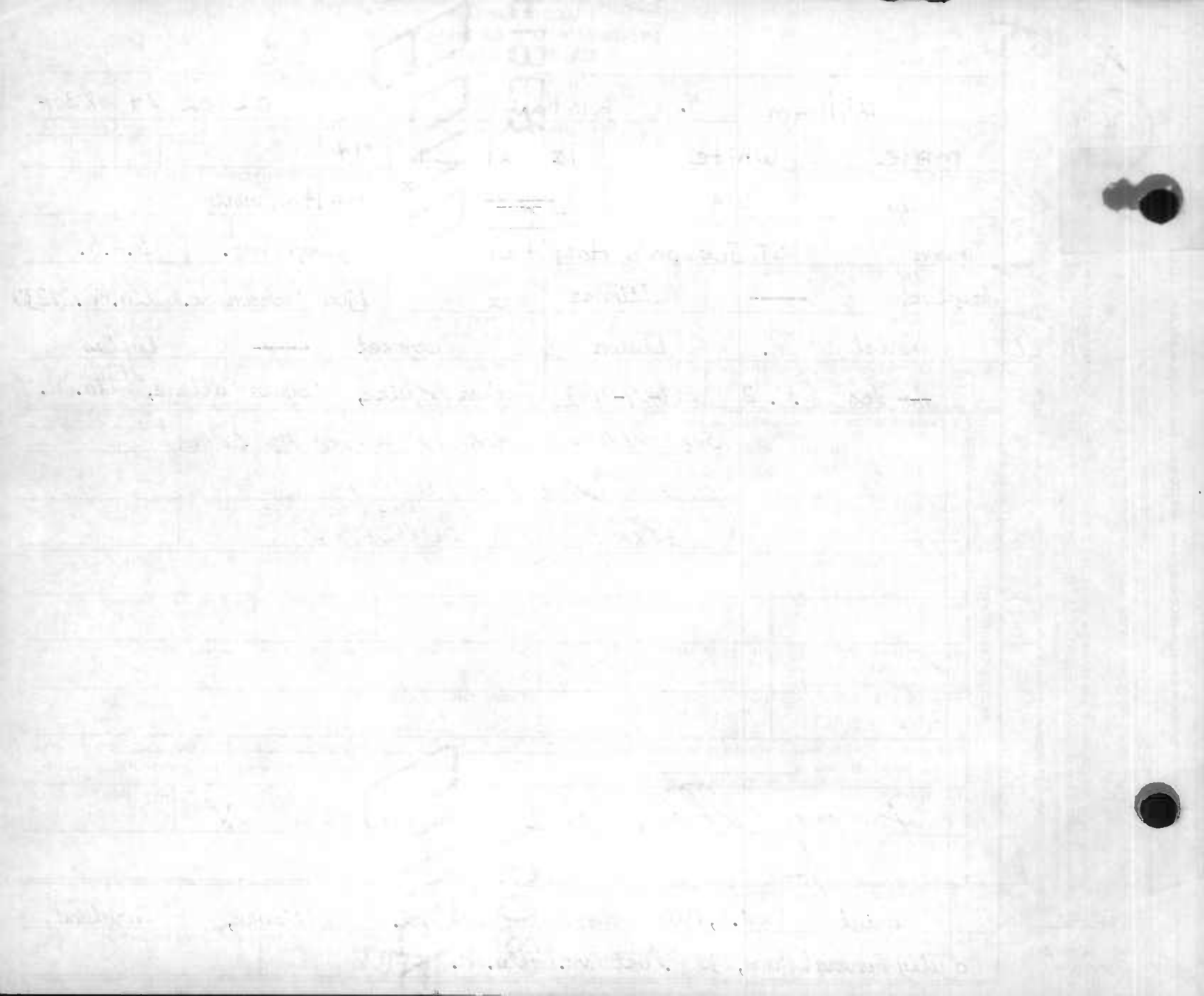
1. DECEASED NAME (TYPE OR PRINT) William J. Liston			2a. DATE OF DEATH MONTH DAY YEAR 02 02 84			2b. HOUR 8 30 A.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10 21 09		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Group Mang.		12b. KIND OF BUSINESS OR INDUSTRY J.R.S.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY N		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel A. Liston		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Loftus		13e. STREET ADDRESS / ZIP CODE 1506 Jackson St. Balto. Md. 21230			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No Yes W.W. 2		16b. SOCIAL SECURITY NO. 213-09-0143		17. INFORMANT ADDRESS Father McGuire, Loyola College, 21210 Balto. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3109 IMMEDIATE CAUSE (a) SUBARACHNOID AND SUBDURAL HEMORRHAGE bilater							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL INFARCTION-HYDROCEPHALUS-PNEUMONITIS							
DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC BRAIN SYNDROME							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Denny Quinn, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sat. 4, 1984		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemt.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME McCutty Funeral Home, 130 E. Port Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR FEB 2 1984		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										0 3 4 9 5									
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH						MONTH		DAY		YEAR		2b. HOUR	
WILLIAM C. LITSINGER						2						21		84		10:26		A	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		White		1 8 08				76				YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Wash., D.C.		U.S.						Balto. County MD.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Towson				Greater Balto. Med. Ctr.				Personnel				County							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Md.				Timonium				YES <input type="checkbox"/> NO <input type="checkbox"/>				2300 Chetwood Circle 21093							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
James Ernest Litsinger				Adele Clunet															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
No				216-07-0354				Mr. Wm. Litsinger, Jr. Baldwin, Md. 4301 Old Farm Rd.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>massive intracerebral bleed 9/83</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Seizure disorder since 9/83</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> 19 <u>80</u> , to <u>2/21</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED							
22b. SIGNATURE <u>Stephen Laiken</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>2/22/84</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS															
Stephen Laiken, M.D.				6805 York Road, Balto., Md., 21212															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Removal				2/21/84															
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Anatomy Board				Balto., Md.				FEB 28 1984				Julia Davidson-Randall							

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20% COTTON

CHILE



SEITE 111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "other" any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth Gladys Logan</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>February 21 1984</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 31, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>69</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Balto.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7101 Rich Hill Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Public Relations, Sinai</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hosp.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Luke Manley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Mitchell</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>097-10-2957</b>		17. INFORMANT ADDRESS <b>Deborah Logan Leilich, Bowie, Md. 20715</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4360 STROKE</b> IMMEDIATE CAUSE (a) <b>STROKE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>16 Nov 1983</b> , to <b>1984</b> , that (I) (we) last saw the deceased alive on <b>16 Nov 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert E. Mason</b> MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>22 Feb 84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert E. Mason, M.D.</b>				22e. ADDRESS <b>9 E. Chase St.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>2-22-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Fun'l. Home, 1050 York Rd., Towson Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson</b>	

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03497

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary - Lombardi			2a. DATE OF DEATH MONTH DAY YEAR Feb. 27, 1984		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 28, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Parkville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9614 Oak Summit Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Baltimore	13c. CITY OR TOWN Parkville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Antonio - Rotolo			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Domenica Della Croce		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-26-9690		17. INFORMANT ADDRESS Mr. William Lombardi Same	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4100 IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on JAN. 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Dr. Celar Parra	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2/28/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Celar Parra		22e. ADDRESS 7122 Harford Rd. Baltimore, Maryland	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Mar. 1, 1984	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley	23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto. Md.
24. FUNERAL DIRECTOR NAME Leonard J. Ruck Inc. Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR FEB 28 1984	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

THE UNIVERSITY OF CHICAGO  
LIBRARY



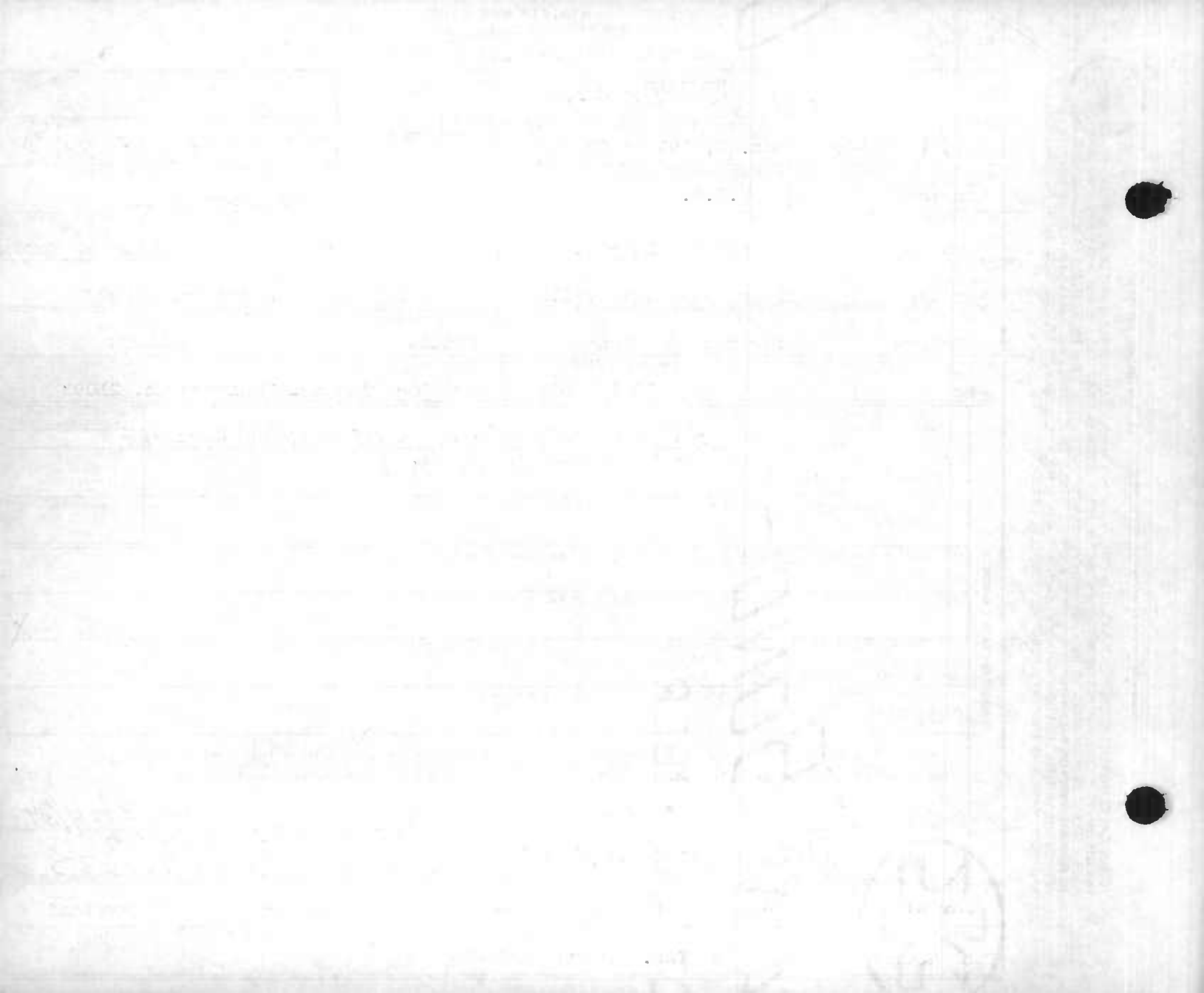
*[Faint, mostly illegible text and markings on lined paper, possibly bleed-through from the reverse side.]*

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN RICHARD LONG, SR.</b>		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 19		2b. HOUR M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 9, 1918</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>65</b> YRS.	IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Lutherville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Ellsworth Long</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie Halbert</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-18-8051</b>		17. INFORMANT ADDRESS <b>Mary Lou Pitt 802 Roundtop Ct. 21093</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		TITLE (SPECIFY) <b>DEPUTY</b> M.D.		DATE SIGNED <b>2/24/84</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL F. GUERIN</b>		ADDRESS <b>1311 WESTERN RUN RD COLICEYVILLE MD 21030</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2-28-1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hereford Baptist</b>	23d. LOCATION CITY OR TOWN <b>Hereford</b>	COUNTY <b>Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Richard Randall</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 03499	
1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET E. LORENZO</b>			2a. DATE OF DEATH MONTH <b>2</b> DAY <b>7</b> YEAR <b>84</b>			2b. HOUR <b>4:00 AM</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>2</b> YEAR <b>25</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 72 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE County MD.</b>					
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>KEN PUNCH OP.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Com. Credit Co</b>			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>PARKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>2901 LINGANORE AVE. 21234</b>		
14. FATHER'S NAME FIRST <b>EARL</b> MIDDLE <b></b> LAST <b>BAKER</b>			15. MOTHER'S MAIDEN NAME FIRST <b>ETHEL</b> MIDDLE <b></b> LAST <b>WILSON</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>216 20 6727</b>			17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEVERE METABOLIC ACIDOSIS</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE AND CHRONIC PYELONEPHRITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HEPATIC FATTY METAMORPHOSIS, DEHYDRATION</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Sister Ann M. McCloskey, M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>2/7/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SISTER ANN M. McCLOSKEY M.D.</b>						22e. ADDRESS <b>7620 YORK ROAD, TOWSON, MD 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>FEB 10, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Men. Pk.</b>			23d. LOCATION CITY OR TOWN <b>CARROLL</b> COUNTY <b>MARYLAND</b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>EVANS CHAPLAIN OF MEMORIES HARFORD RD.</b> ADDRESS <b>8800</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 14 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MICHAEL		MIDDLE J.		LAST LOUKOTA		2a. DATE KNOWN OF DEATH MATED		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 10 05		6. AGE (IN YEARS) (LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 2 4 1984		2d. HOUR 6:45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.							
10. CITY OR TOWN OF DEATH Essex		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor-Ret.		12b. KIND OF BUSINESS OR INDUSTRY Balto.		Transit					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS?	
13e. STREET ADDRESS 111 Manor Ave.				13f. CITY OR TOWN Baltimore				13g. STATE Maryland				13h. ZIP CODE 21206	
14. FATHER'S NAME FIRST MIDDLE LAST N/A				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST N7A				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16b. SOCIAL SECURITY NO. 213-19-0060				17. INFORMANT ADDRESS William Raivel 433 N. Clinton St. Balto., Md. 21224				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b). (c).					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Ann M. Dixon, M.D.				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 2-5-84	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St., Balto., MD. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2-9-84				23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				ADDRESS 7401 Belair Rd Balto., Md. 21236				25a. DATE REC'D. BY REGISTRAR FEB 09 1984				25b. REGISTRAR'S SIGNATURE John J. Gwinn	

United States Department of the Interior

George G. Smith

1900

1900



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

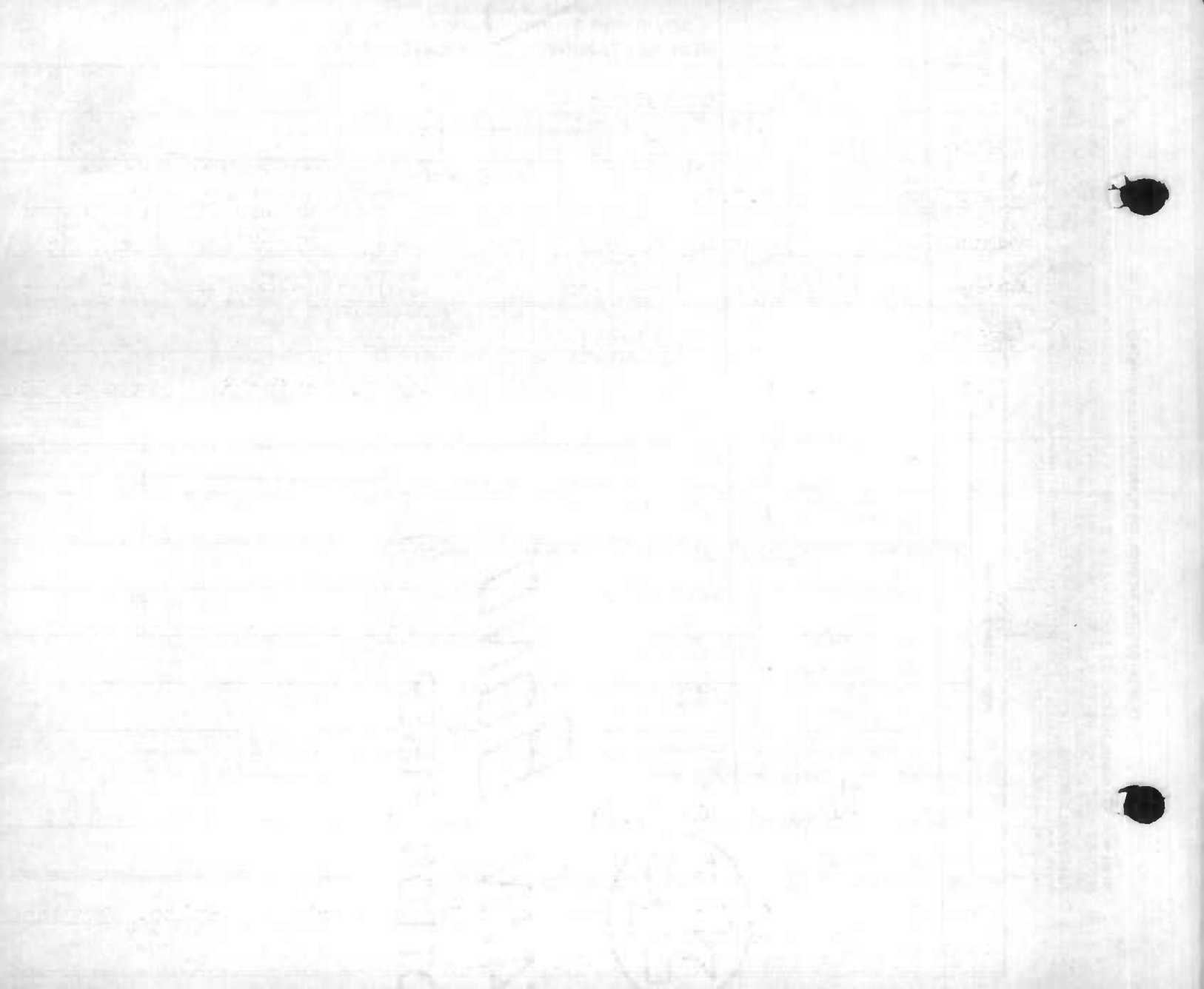
BP

DHMH - 17  
(VR A15 ME (51))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Leonard Stanislaus Lubinski</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>2 14 19 84</b>				2b. HOUR M <b>7P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 21 31</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>52</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>2 20 19 84</b>		2d. HOUR M <b>7P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Dundalk</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8000 Blk. Park Haven Road (in car)</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8013 Park Haven Rd. 21222</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Lubinski</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea</b>		17. INFORMANT <b>Barbara P. Lubinski</b>				ADDRESS <b>Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Margarita A. Korell</b>						TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>2/21/84</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>						ADDRESS <b>111 Penn St. Balto., MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/23/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Ht. Of Jesus</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk Balto. Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>						ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 27 1984</b>		25b. REGISTRAR'S SIGNATURE <i>Carla Gordon-Pendall</i>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

03502

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Katherine</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>February 8, 1984</b>			2b. HOUR <b>1:05pm</b>			
3 SEX <b>Female</b>		4 RACE <b>Col.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-21-25</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Boston, Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>			
10 CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FORMER OR WORKING LIFE) <b>Minister</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Butler</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Lane Butler</b>			16. STREET ADDRESS / ZIP CODE <b>12234 Eastern Ave 21220</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE NAME OF SERVICE) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>294-16-5050</b>		17. INFORMANT ADDRESS <b>Rev. Albert Luckett 12234 Eastern Ave. 21220</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Duct Cell Carcinoma Of Left Breast</b> <b>With Metastasis To Right Parietal Lobe Of Brain</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION <b>2</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>9</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>9000 Franklin square Drive 21237</b>				
22a. I certify that <b>X</b> (this hospital) attended the deceased from <b>January 31, 19 84</b> , to <b>February 8, 19 84</b> , that (1) <b>X</b> (we) last saw the deceased alive on <b>February 8, 19 84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <b>X</b> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Fernando J. Acle, MD</b>			DEGREE <b></b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/8/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Fernando Acle, M.D.</b>			22e. ADDRESS <b>9000 Franklin square Drive 21237</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2-13-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharpston Meth. Ch. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Balto. Co. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Joseph L. Russ</b>			ADDRESS <b>2222 W. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 16 1984</b>		25b. REGISTRAR'S SIGNATURE <b>William R. Riddell</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

